

DOCUMENT PLUS USER MANUAL And Tutorial

Revision 10

**Please read the information enclosed to fully understand the forms
and the program.**

If you are in need of further assistance or would like to schedule training

Please call (800) 642-0600 or (770) 814-2442

DocumentPlus, P.O. Box 820 Duluth, GA 30096
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DOCUMENTPLUS[®]

USER MANUAL

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CONTENTS

Introducing Document Plus (please hold down Ctrl while clicking on link)

<u>Learning DocumentPlus</u>	5
<u>About this Manual</u>	5
<u>For Further Help</u>	6
<u>Document Plus Support</u>	6
<u>Training</u>	6
<u>Technical Support</u>	6
<u>Scanner Warranty Information</u>	6
<u>Getting Started</u>	7
<u>Computer Requirements</u>	7
<u>Preparing Your Computer</u>	8
<u>Installation</u>	8
<u>Current Interfaces with Practice Management Systems</u>	8
<u>Ordering Forms</u>	9
<u>The Forms – Overview</u>	9

Section A: Initial Setup

<u>Setting Up Document Plus</u>	10
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Section B: DocumentPlus Tutorial I – “Basic”

<u>Using Document Plus</u>	11
<u>Step 1: Setting Up Your Practice Demographics</u>	12-22
<u>Entering Information into the Doctor Database</u>	12-15
<u>Entering Information into the Attorney Database</u>	16
<u>Entering Information into the Insurance Database</u>	17
<u>Entering Information into the Patient Database</u>	18-22
<u>Step 2: Scanning the Forms</u>	23-26
<u>Scan the Forms</u>	24-25
<u>Validation WARNING</u>	25
<u>Validation ERROR</u>	26

<u>Step 3: Generating Documents</u>	27-31
<u>Overview</u>	27
<u>Reports/Summaries</u>	28
<u>Consultation Note</u>	29-30
<u>Patient Letters</u>	30-31
<u>Controls</u>	31
<u>Queries</u>	32-36
<u>Completing the Query Screens</u>	32-33
<u>Customizing Queries</u>	33-36
<u>Reports (Required Forms)</u>	37

Section C: Document Plus Tutorial II – “Daily Note/Travel Card”

<u>Step 1: Filling out the Daily Note (DN3c) form</u>	38-54
<u>Date, DR#, Patient Number</u>	39
<u>Symptoms</u>	40-42
<u>Symptoms, Section I</u>	40
<u>Symptoms, Section II</u>	41-42
<u>Assessment</u>	43
<u>Diagnosis</u>	43
<u>Progress</u>	43
<u>Plan</u>	44
<u>Today’s Treatment, Modalities</u>	45
<u>Rehab Therapy</u>	46
<u>Man/Adj</u>	47-48
<u>X-Rays</u>	49
<u>Objective</u>	50-51
<u>Thrust Report</u>	52
<u>Today’s Tx, General Listings</u>	53
<u>SOAP, Of Additional Note</u>	54
<u>Step 2: Scanning the Daily Note Form</u>	55
<u>Step 3: Generating the Daily Note Report</u>	56-57
<u>Summary</u>	58

<u>Before Printing the Travel Card</u>	59-60
<u>Step 4: Printing Travel Cards</u>	61-62
<u>Customizing Travel Card Setup</u>	62
<u>Understanding the Travel Card – Part I</u>	63-65
<u>Step 5: Filling out the Daily Note Form – Second Visit</u>	66-67
<u>Understanding the Travel Card – Part II</u>	68-69
<u>Step 6: Filling out the Daily Note Form – Third Visit</u>	70-71

Section D: “Advanced Setup” - Setting Your Preferences

<u>Setting Your Preferences</u>	72-78
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Appendixes: A-J

<u>Appendix A</u> – “Customizing the Daily Note (DN3c) Form”.....	79-84
<u>Appendix B</u> – “Outcome Assessment Questionnaires”.....	85-86
<u>Appendix C</u> – “Scanning Images”.....	87-92
<u>Appendix D</u> – “P.A.R.T. for Medicare”.....	93-98
<u>Appendix E</u> – “CE Version 3 Instructions”.....	99-113
<u>Appendix F</u> – “List” Functions”.....	114-116
<u>Appendix G</u> – “Utilities” Functions.....	117-118
<u>Appendix H</u> – “Including Images in your Radiographic Report”.....	119-123
<u>Appendix I</u> – “Word Processing”	124-125
<u>Appendix J</u> – “Abbreviations”.....	126-139

Introducing DocumentPlus

Thank you for selecting Document Plus. We believe our product and service will exceed your expectations for report writing and documentation.

DocumentPlus is easy to use and serves as a powerful practice building tool. Use it to produce a variety of professional reports for patients, attorneys, insurance companies and other doctors.

Learning DocumentPlus

DocumentPlus is easy to learn and use. **This tutorial will provide an overview of the program and give you the basic information you need to get started.** You will want to watch the training and informational DVDs (located in your starter kit or online at www.docplus.net) and complete this step-by-step tutorial. Please call the Document Plus training department at (800)642-0600 to schedule further telephone training.

About This Manual

Introducing Document Plus

- Support, training, and scanner warranty information
- Computer requirements
- Preparation for installation of your software
- Forms – Ordering Information and form descriptions

Section A: Initial Setup

- Step by step instructions for the “Setup, Settings” screen.

Section B: Document Plus Tutorial I – “Basic”

- Comprehensive tutorial takes you through a basic insurance case from start to finish
- Enter information into Doctor, Attorney, Insurance, and Patient databases.
- Scan forms
- Generate summary reports and comprehensive narratives

Section C: Document Plus Tutorial II – “Daily Note/Travel Card”

- Step by Step guide to completing the daily note form (DN3c)
- Using “Same As” bubbles (DN3 form)
- Printing and Understanding the travel card

Section D: Advanced Setup – Setting Your Preferences

- Detailed outline of the Setup screens

Appendixes A-J:

- Additional helpful information with various program features, forms, and guidelines.

For Further Help

Document Plus provides technical assistance as well as scheduled telephone training sessions. If you need assistance with the software or the scanner, please call our technical support department at **(800) 642-0600**.

Document Plus Support: The Document Plus software is sold with 90 days of unlimited technical support and training via telephone. Following the 90 day period, annual support contracts are available. The annual support contract includes unlimited technical support, training and software upgrades. Should you choose not to take advantage of the annual contract we are happy to provide technical support and training at an hourly rate. Software upgrades will be available at an additional charge.

You will be notified by mail when your 90 day free support expires. This notification will include the current yearly support rate. Please call us at (800) 642-0600 should you have any further questions.

Training is available by telephone. To schedule session(s) call (800) 642-0600. We also offer virtual/telephone training for customers with internet access.

IN PREPARATION FOR TRAINING:

- Be sure your software and scanner are installed and have been verified by our technical support department.
- Download and print the [Bob Jones' Sample Case](#) and complete your forms according to the instructions.
- Plan for a minimum of 1 ½ to 2 hours of uninterrupted time to complete each session.

NOTE: Training consists of two parts; a “**Basic**” and a “**Daily Note/Travel Card**” session.

Technical Support is available by telephone. Call (800) 642-0600 to install Document Plus.

Scanner Warranty: For a period of one year from date of purchase, any damage due to defective material or workmanship will be repaired at no charge.

Note that abusive wear and tear or damage caused by accident, disaster, misuse, unauthorized modifications and unauthorized service is not covered. In such cases, charges are at the discretion of Document Plus Technology, Inc.

An extended warranty is available. Contact a Document Plus representative for details. Under extended warranty, should a problem occur with the scanner, simply call technical support at (800) 642-0600. They will assist you in determining the source of the problem and, if a part of the machine is defective, will ship you a loaner scanner within 24 hours.

Your obligation under this plan is to return the defective scanner using the same carton in which the new scanner arrived.

If a scanner is not covered under warranty, charges will apply for parts, labor, and shipping.

Getting Started

Computer Requirements

COMPUTER	Minimum	Recommended
Processor:	Pentium III 800	Pentium 4 800 or faster
Free Hard Disk Space: after installing Microsoft Word	500 MB	1 GB or more
RAM:	256MB	512MB or more
Ports: (Document Plus Supplied)	USB 2.0 port	USB 2.0 port
PERIPHERALS	Minimum	Recommended
Drives:	CD-ROM	CD-ROM
Printer:	300 x 300 dpi 0.25" or smaller minimum margins	600 x 600 dpi laser 0.25" or smaller minimum margins
Mouse:	Any	Any
SOFTWARE/Operating Systems		
Supported	Windows 2000/ Windows XP / Windows Vista	
*Word Processor:	Microsoft Word 10.0 or higher	
Internet Access: This allows us to connect to your computer remotely (*Required for virtual training).		
*Customer supplied and required		

For Technical Assistance call: 1-800-642-0600

Preparing Your Computer

Complete the following steps to prepare your computer for installing Document Plus. If you need assistance, please call technical support at 800-642-0600.

1. Confirm that there is at least 500 MB of free space on your hard drive.
2. Temporarily close or disable any programs.
3. Install Microsoft Word and confirm that you are able to open the program.
4. Install Document Plus.
5. Install USB hub. (**BEFORE** installing the scanner, be certain that the **USB hub** included in your initial shipment is installed. This will prevent hardware problems from occurring.)
6. Install scanner.

Installation

Call our technical support department at 800-642-0600 to install the Document Plus system. If you have one of the Practice Management programs listed below ask the tech support representative to configure the interface.

Current Interfaces with Practice Management Systems:

ACS- 800-375-2271 Price: Free

AMS- 800-440-6949 Price: Free

DB Consultants- 610-847-5065 Price: Free

EZ Bis- 800-445-7816 Price: \$295

Genius Solutions- 586-751-9080 Price: \$295

Eclipse- 800-966-1462 Price: Free

Formsmith Systems Inc.- 770-478-2191 Price: Free

Herfert-586-776-2880 Price: Free

Inphase-800-490-3780 Price: Free

Sunrise Systems and Solutions- 330-386-9300 Price: Free

TGI (Autumn8) - 800-645-4309 Price: \$299

Nutritional Interface Partners

Symptom Survey Maestro- 585-924-4456

Computerized Fixation Imaging

Pulstar- 800-628-9416

Visit www.docplus.net for more information regarding Practice Management partners.

Ordering Forms

Included with your initial purchase are 250 daily note forms and 25 each of all other available forms. This will help you decide which forms your office will use. To insure that you always have an adequate stock of forms, you can order using any of the following methods.

TO ORDER FORMS: CALL: 800- 642-0600, **FAX:** a forms order sheet (included in the starter kit) to 770- 814-9988, Or visit us **ONLINE:** <http://www.docplus.net>. For expedited service, **overnight shipping is available.**

The Forms - Overview

In this guide, the term **FORM** refers to various forms filled in by the patient and clinician. The Forms are:

- **Health Questionnaire**-3 types (HQ#0, HQ#2 and HQ#3) - To be completed by a new patient on an initial visit or an existing patient upon starting a new case.
- **Clinical Evaluation**- 2 types (CE#0/2 or CE#3) - To be completed by the clinician. This form details the findings of initial exam.
- **Radiographic Examination** – 2 types (RD#0 and RD#2) - To be completed by the clinician.
- **Re-evaluation** - 2 types (RE#2 or RE#3) - To be completed by clinician. This form details the findings of the re-exam.
- **Automobile Crash** (AA0a) - The patient completes this form. Details of the automobile accident such as road conditions, number of vehicles involved, etc.
- **Accident/Injury** (AI#0/2) - The patient completes this form. This form explains in detail, the injuries of the patient.
- **Daily Notes** - 2 types (DN#3, DN#4) - To be completed by the clinician.
- **Outcome Measures** - 4 types (RO, RM, NP, HS) - To be completed by the patients as the clinician deems necessary to assess treatment and progress.
- **Spanish Forms** - 3 types (HQ, AA, AI) – These forms are to be completed by the patient.
- **Symptom Survey** – This form must be used in conjunction with Symptom Survey Maestro Software. If you are interested in using this form and do not have Symptom Survey Maestro you can contact them at 585-924-4456 or go to their website www.surveymaestro.com

Section A: “Initial Setup”

After the installation and before you start using the system, complete the steps below.

1. From the Main Menu click “Set-up”.

You are now in the “Setup Information” screen, “Settings” tab. (Figure 1 below) Complete the following steps to customize the “Settings” screen:

Figure 1- “Setup Information” screen, “Settings” tab

The screenshot shows the 'Setup Information' window with the 'Settings' tab selected. The window title is 'Document Plus, Version 10.00 - Miscellaneous (MISC.EXE) [WkSta:ServerActiv]'. The 'Settings' tab contains the following fields and options:

- Practice Name:** Pompano back repair
- City:** Pompano Beach
- State:** FL
- Country:** USA
- Scanner:** DP_VX
- Port:** (empty)
- Baud Rate:** (empty)
- Light:** (empty)
- Dark:** .015
- Word Processor:** Microsoft Word
- Documents Path:** C:\DP_DATA\PATIENT LETTERS\ (Not Shared) (Not Global)
- PRACTICE MANAGEMENT:** Software: None, Empty, Time Out: 0
- Acknowledge:** New, Modify, Delete, Setup, DBC Appt, Proper, Insured: Query
- PM Data Path:** (empty)
- Export Mode:** None
- Software:** None
- File:** CHARGES.IMP
- Service:** (empty)
- Topic:** (empty)
- Export Path:** (empty)

At the bottom, there are buttons for 'Document' (Layout - Letter, Layout - Report) and 'Actions' (Save, Cancel). The status bar at the bottom shows 'Pmsware [c:\docplus9.010\dbf\pm\pmsware.dbf]', 'Record: EOF/11', 'Record Unlock', 'NUM', and '10:34:48'.

2. Verify your city and state.
3. Enter your practice name. This is the name that will appear as the “footer” on your reports.
4. Select the scanner type (**DocPlus**). (Only applies to the computer where the scanner is connected)
You will see a “YES/NO” option for enabling the pain diagram. If you select “YES”, the pain diagram (DN3, Pg. 2, section 2) will appear, with the patient signature and date, in your generated daily note report ([See Figure 3B, Page 42](#) and [Figure 16, Page 57](#)). If you select “NO”, it will not appear in the report.
5. To select the word processor, click on the pull down arrow and select “Microsoft Word”.

NOTE: Once the version is displayed click “Save”.

6. PRACTICE MANAGEMENT: Please call our technical support department for help setting up your billing software interface. (See Pg. 8 to view current interface partners)

NOTE: Additional options located within the “Advanced Setup” screens can be found on Pages [72-78](#). Many of those options are related to customizing user preferences for reports and narratives. It is recommended that you complete the step-by-step tutorial before customizing the “Advanced Setup” screens.

Section B: Document Plus Tutorial I – “Basic”

USING DOCUMENT PLUS

Introduction

This step-by-step tutorial will give you a working knowledge of the Document Plus system by taking you through a test case. You will be entering information into the database, scanning forms and generating documents. Upon completion of this tutorial, if you need further assistance please call our office at 800-642-0600 to schedule a training session.

To begin the tutorial it is necessary to complete a case study. Download and print the [Bob Jones Sample Case](#). **Transfer the information from the sample copies** of the Health Questionnaire (HQ3), Clinical Evaluation (CE3), and Radiographic Examination (RD2) **onto actual bubble forms** (located in your starter kit) using a **NO. 2 Pencil**.

There are three steps to generating reports in DocumentPlus: (See Figure 1 below)

1. Enter patient information into the database
2. Scan bubble forms.
3. Generate the Documents

Figure 1: Document Plus “Main Menu”



STEP 1: SETTING UP YOUR PRACTICE DEMOGRAPHICS

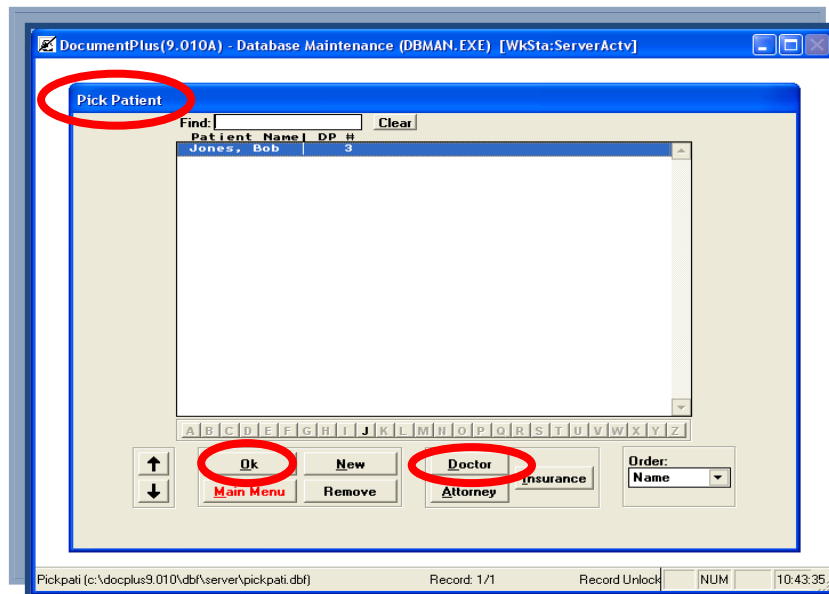
This section of the tutorial will guide you through entering information into each of the four Document Plus databases (“Doctor”, “Attorney”, “Insurance”, and “Patient”).

A. ENTERING INFORMATION INTO THE DOCTOR DATABASE

1. From the Main Menu, click **“Databases”**. (See Figure 1, Pg.11)

NOTE: You are in the **“Pick Patient”** screen. Your screen will appear blank since no patients have been entered into the database.

Figure 2 – “Pick Patient” screen



2. Click the **“Doctor”** button. (See Figure 2 above)

NOTE: You are now in the “Pick Doctor” screen. (See Figure 3 below)

Figure 3 – “Pick Doctor” screen

DocumentPlus(9.010A) - Database Maintenance (DBMAN.EXE) [WkSta:ServerActv]

Pick Doctor

Find: Clear

Doctor's Name: Your, Doctor, D.C. Id/PM Ref: H001

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

↑ ↓ Ok New Main Menu Patient Attorney Insurance Doctor Type: All

Ckidno (c:\docplus9.010\dbf\server\ckidno.dbf) Record: 4/6 Record Unlock NUM 10:48:38

3. Double click to select YOUR doctor's name. (See Figure 3 above)

NOTE: You are now in the “Doctor Information” screen. (See Figure 4 below)

4. Verify your doctor's name, credentials, address, and phone information.

Figure 4 – “Doctor Information” screen- In House

DocumentPlus(9.010A) - Database Maintenance (DBMAN.EXE) [WkSta:ServerActv]

Doctor Information - Dr. Doctor Your, D.C. (001)

Information 1 Information 2

Name:
Type: In-House ID Number: 001 PM Ref:
Title: Dr. First name: Doctor Middle Last name: Your Credentials: D.C.
Letter Greeting: Dr. Your Letter Signature: Doctor Your, D.C. Insurance Signature: Doctor Your, D.C.

Address:
Street: 123 E Federal Hwy Suite 1a City: Pompano Beach FL 33062- State Zip Code
E-Mail: doc@aol.com

Phone Numbers:
Office 1: (444) 123-4567 Office 2: (444) 132-4568 Fax: (444) 132-5000 Home: () -

Save Main Menu Pick Doctor New Remove Doctor Patient Attorney Insurance

Doctor (c:\docplus9.010\dbf\server\doctor.dbf) Record: 1/1 Record Locked NUM 10:52:18

5. Click “Save”, then click the “Pick Doctor” button.

NOTE: You are returned to the “Pick Doctor” screen. (See Figure 5 below)

Figure 5 – “Pick Doctor” screen

We will now enter the information for Bob Jones’ “Personal Physician”. This information can be found on the Health Questionnaire (HQ3) Form, Pg. 3, question G1b.

1. Click “New”. (See Figure 5 above)

NOTE: You are in the “Doctor Information” screen. Your screen will appear EMPTY. In Figure 6 (below) the physician information has already been entered.

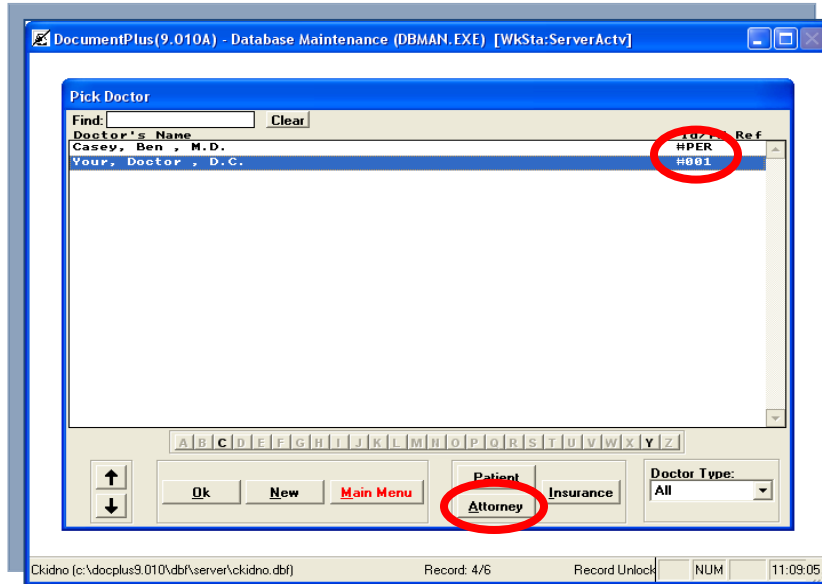
2. Use the pull down menu to select “Personal” as the “Type” of doctor you are entering information for.
3. Tab over to “Title” and enter the information for “Dr. Ben Casey” as shown below in Figure 6.

Figure 6 – “Doctor Information” screen – Personal Physician

- Click “Save”, then click the “Pick Doctor” button.

NOTE: You are now at the “Pick Doctor” screen where all doctors are listed. (See Figure 7 below)

Figure 7 – “Pick Doctor” screen

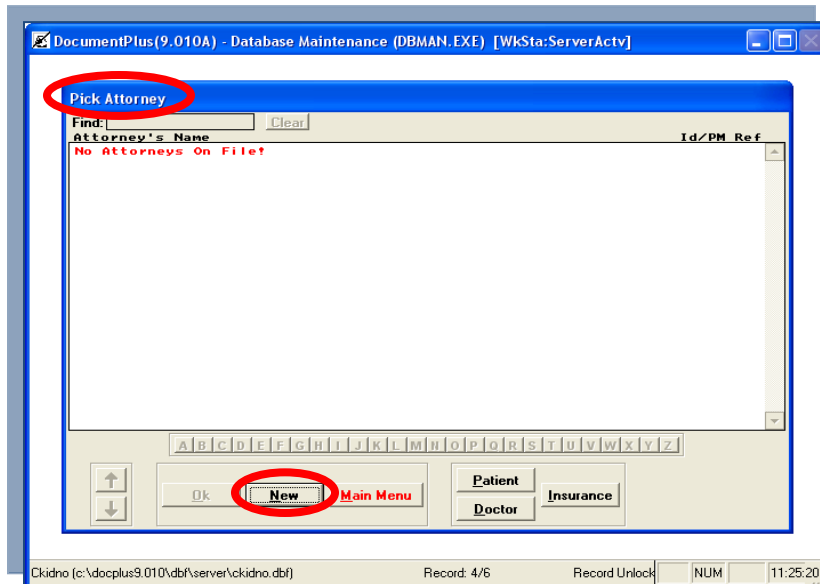


- Notice that “Ben Casey, M.D.” is now listed in the doctor database and that he is categorized as a personal physician (#PER).
- Click the “Attorney” button (to access the “Attorney” database).

B. ENTERING INFORMATION INTO THE ATTORNEY DATABASE

NOTE: You are now in the “Pick Attorney” screen. You currently have no attorneys listed here.

Figure 8 – “Pick Attorney” screen



We will now enter the information for Bob Jones’ “Attorney”

1. Click “New”. (to enter a new attorney)

NOTE: You are now in the “Attorney Information” screen. Your screen will appear EMPTY. In Figure 9 (below) the attorney information has already been entered.

2. Tab over to “Title” and enter the information as shown below in Figure 9.

Figure 9 – “Attorney Information” screen

3. Click “Save”, then click the “Insurance” button (see Figure 9 above).

C. ENTERING INFORMATION INTO THE INSURANCE DATABASE.

NOTE: You are now in the “Pick Insurance Company” screen. (See Figure 10 below)

Figure 10 – “Pick Insurance Company” screen

NOTE: American Specialty Health Plans (ASHP) is pre-programmed into your software.

We will now enter the information for a new “Insurance Company”.

1. Click “New” (to enter a new insurance company).

NOTE: You are in the “Insurance Company Information” screen. Your screen will appear EMPTY. In Figure 11 (below) the insurance information has already been entered.

2. Tab over to “Company Name” and enter the information as shown below in Figure 11.

Figure 11 – “Insurance Company Information” screen

NOTE: If you do not have a practice management software that interfaces with Document Plus the “PM reference” field along with “Phone Numbers” are for in house use and do not appear in any reports.

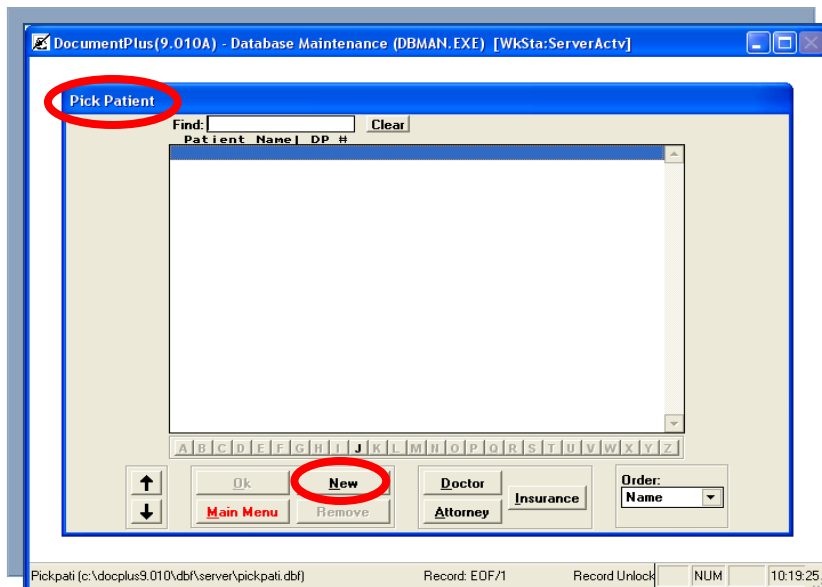
NOTE: If “Medicare Format” is selected, reports and narratives associated with this insurance company will have the patient’s date of birth and Medicare ID at the top of the page and the doctor’s signature at the bottom.

3. Click “Save”, then click the “Patient” button.

D. ENTERING INFORMATION INTO THE PATIENT DATABASE

NOTE: You are in the “Pick Patient” screen. (See Figure 12 below)

Figure 12 – “Pick Patient” screen



We will now enter the information for a new “Patient”. The Bob Jones new patient information can be found on the “Confidential Patient Information” sheet that was completed for this training.

1. Click “New” (to enter a new patient)

NOTE: You are in the “Patient Information 1” screen. Your screen will appear EMPTY. In Figure 13 (below) the patient information has already been entered.

2. Enter a “DocPlus Number” (#3 for Bob Jones).
3. Tab over to “Title” and enter the information for **Mr. Bob Jones** as shown below in Figure 13.

Figure 13 – “Patient Information 1” screen

The screenshot shows the 'Patient Information 1 - Jones, Bob (# 3)' window. The title bar is the same as Figure 12. The window has a tabbed interface with tabs for 'Information 1', 'Information 2', 'Insurance 1', 'Insurance 2', 'Accident', 'Notes', 'Social History', and 'Forms'. The 'Information 1' tab is selected and circled in red. The form contains the following fields: 'DocPlus Number' (0000000003), 'Name' (Title: Mr., First: Bob, Mid: , Last: Jones), 'Letter Greeting' (Mr. Jones), 'Street' (123 Main Street), 'Apt' (Y), 'City' (Pompano Beach), 'State' (FL), 'Zip Code' (35648-), 'Home Phone' ((813) 596-4587), 'Work Phone' ((813) 589-6542), 'Fax' (() -), 'Birthdate' (10/05/1952), 'Age' (59), 'Sex' (Male), 'Employment Related Condition' (No), 'Auto/PI Related Condition' (No), 'SSN' (555-55-5555), 'HIC' (555-55-5555A), and 'Driver Lic. #'. At the bottom, there are buttons: 'Save' (circled in red), 'Main Menu', 'Pick Patient', 'New', 'Remove Patient', 'Doctor', 'Insurance', and 'Attorney'. The status bar at the bottom shows 'Ckidno (c:\docplus9.010\vb\server\ckidno.dbf)', 'Record: 2/6', 'Record Unlock', 'NUM', and the time '10:24:37'.

- Click “Save”, then select the “**Information 2**” tab at the top of your screen.

NOTE: You are now in the “Patient Information 2” screen. (See Figure 14 below)

Figure 14 – “Patient Information 2” screen

DocumentPlus(9.010A) - Database Maintenance (DBMAN.EXE) [WkSta:ServerActv]

Patient Information 2 - Jones, Bob (# 3)

Information 1 **Information 2** Insurance 1 Insurance 2 Accident Notes Social History Forms

Primary Doctor Type:

Pick Doctor: Your, Doctor, D.C. #001

Pick Referred From:

Pick Referring Patient:

Pick Referred To:

Pick Personal Physician: Casey, Ben, M.D. #PER

Pick Patient's Attorney: Howe, Harry, Esq. #ATT

Dates:

Entered Practice: 01/18/2012 First Consultation:

Initial Exam: Last Activity:

Last Re-Exam: Re-Exam Scheduled:

Current Re-Exam: X-Rays Scheduled:

Next Appointment: 0:00 AM PM

Case Number: *

Last Visit / Visits: 0

Visits Of Plan: 0 Approved: 0

Visits Schedule:

Treatment Phase:

Save Main Menu Pick Patient New Remove Patient Doctor Attorney Insurance

Patient (c:\docplus9.010\dbf\server\patient.dbf) Record: 2/2 Record Locked NUM 10:36:16

NOTE: This screen enables you to link the In-House doctor seeing the patient, Primary Care Physician, and Attorney to the selected patient. If linked here, the information will be associated with the patient when generating narratives.

- Click the “**Pick**” button to the left of the word “**Doctor**”. A list of “**In-House**” doctors will appear. Select the doctor from your office that will be treating this patient. Click “**Ok**”.
- Repeat for the “**Personal Physician**” (Ben Casey) and “**Patient’s Attorney**” (Harry Howe)
- Click “**Save**”, then select the “**Insurance 1**” tab at the top of your screen.

NOTE: You are now in the “Primary Insurance Information” screen. (See Figure 15 below)

Figure 15 – “Primary Insurance Information” screen

DocumentPlus(9.010A) - Database Maintenance (DBMAN.EXE) [WkSta:ServerActv]

Primary Insurance Information - Jones, Bob (# 3)

Information 1 Information 2 **Insurance 1** Insurance 2 Accident Notes Social History Forms

Relation to Insured: Self

Primary Insured's Name:
Mr. Bob Jones
Title First name Middle Last name Pick

Primary Insured's Address and Phone:
Street: 123 Main Street Home Phone: (813) 596-4567
Apt. Y Office Phone: (813) 589-6542
City: Pompano Beach State: FL Zip Code: 35648-

Primary Insurance Carriers:
Company: Pick
Insured group #: Insured's ID #:
Patient's Insured ID #: Claim #:
Annual \$ Max/# Visits: 0 Co-Pay: \$ 0.

Save Main Menu Pick Patient New Remove Patient Doctor Attorney Insurance

Insured (c:\docplus9.010\dbf\server\insured.dbf) Record: None Record Unlock: NUM 10:39:17

NOTE: In this screen you can select an insurance company in association with the selected patient. If linked here, the information will appear automatically in the appropriate fields when generating narratives.

NOTE: This is the screen where you will select the primary insurance carrier for the selected patient.

8. Enter the information as shown in **Figure 15** above.
 - a. **Relation to Insured:** Use the pull down menu to select “Self”. (This will automatically fill in the patient information.) **Notice:** You also have the option to select “Spouse”, “Child”, or “Other”. If you select one of these options, you may use the “Pick” button to the right of “Last Name” to select the primary insured’s name or simply type the information into the provided fields.
 - b. Use the “Pick” button in the “Primary Insurance Carriers” section to open the “Insurance” database and select the insurance company name.
9. Click “Save”, then select the “Insurance 2” tab at the top of your screen.

Figure 16 – “Secondary Insurance Information” screen

NOTE: You will only be using this screen when you are billing a secondary insurance company. For this tutorial, we will not be entering any information in this screen.

- NOTE: You are now in the “Social History Information” screen. (See Figure 17 below)**

Figure 17 – “Social History Information” screen

1. Enter the information in the “**Employer**” and “**Employed as**” fields as shown above in **Figure 17**.

NOTE: You are only required to enter employment information in this screen. The remaining information will be filled in automatically when the Health Questionnaire (HQ2, HQ3) form is scanned.

2. Click “Save”, then select the “Forms” tab at the top of your screen.

NOTE: You are now in the “Patient’s Scanned Forms” screen. Your screen will appear EMPTY because you currently have no forms scanned for this patient. Figure 18 (below) shows this screen with initial intake forms scanned for the selected patient.

Figure 18 – “Patient’s Scanned Forms” screen

DocumentPlus(9.003B) - Database Maintenance (DBMAN_B.EXE) [WkSta:SANDY]

Patient's Scanned Forms: Jones, Bob (# 3)

Information 1	Information 2	Insurance 1	Insurance 2	Accident	Notes	Social History	Forms
Exam Date	Form Id	Serial No	Doctor #	Scan Date			
01/07/2008	CE - 3a	449071	1	01/30/2008			
01/07/2008	HQ - 3a	275915	1	02/04/2008			
01/07/2008	RD - 2	39572	1	01/18/2008			

Date Order:
☒ Ascending
☐ Descending

Sort By:
 Exam Date

Print List

Case Number

CE3>RE3

Save Main Menu Pick Patient New Remove Form Doctor Attorney Insurance

CE#3-449071 NUM 14:45:21

This screen lists all the forms that have been scanned for the selected patient. The functions in this screen are outlined below.

- a. **To delete a form** - Click on the form you wish to remove. Once highlighted, click the “Remove Form” button. **Once the form is deleted it CANNOT be rescanned.**
- b. **To change CE3 to RE3 (or RE3 to CE3)** - If you scan a Clinical RE-Evaluation with “Clinical Evaluation” bubbled on the form, click on the “CE3” form you wish to modify and click the “CE3>RE3” button. This allows you to change the “Clinical Eval” to a “Clinical Re-Eval” (or a “Clinical Re-Eval” to a “Clinical Eval” (RE3>CE3).
- c. **To change HQ3 to HQR3 (or HQR3 to HQ3)** - If you scan a Health Questionnaire RE-Evaluation with “Initial” bubbled on the form, click on the “HQ3” form you wish to modify and click the “HQ3>HQR3” button. This allows you to change the “Initial” to a “Re-Eval” (or a “Re-Eval” to an “Initial” (HQR>HQ3).

NOTE: The “Notes” tab will be covered in the Daily Note portion of this tutorial. The “Accident” tab is for office reference only.

Click “Main Menu” and proceed with “Step 2: Scanning the Forms”.

STEP 2: SCANNING THE FORMS

READ THIS PAGE BEFORE SCANNING!!

Overview

The next step is to scan the forms that you have prepared. Listed below are some tips that will make scanning easy and prevent unnecessary errors.

Scanning Tips

- Wait to scan forms until the screen reads **[Scanner Ready - Feed Forms]**.
- The scanner will read both sides of the form at once.
- Make sure that the doctor number, patient number and date fields are correct and right justified on the form. (For patient #3 you would bubble “3” in the column farthest to the right in the “**Patient Number**” section. [\(See Figure 1, Pg. 39\)](#))
- When using forms with multiple sheets, separate them at the perforated fold before scanning.
- Forms are fed one sheet at a time.
- The forms **must** be fed into the scanner according to the following: **Odd** numbered pages should **face up** (i.e. 1, 3, 5, and 7) and the **bottom** should go in **first**.
- Once the forms are scanned, press “**Enter**”. The bubbled information is then saved into the program.
- Forms for different patients may be scanned at the same time. Each form that is scanned is saved for the specific patient according to the “**Patient Number**” bubbled on the form and the unique serial number at the bottom of each sheet.

Figure 19 - Form Orientation into the Scanner

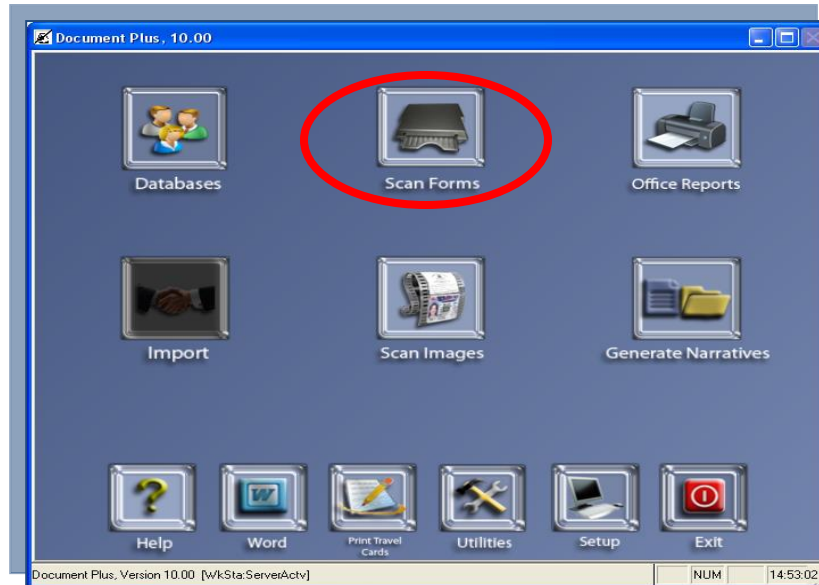
Double Click on the Image below to play



SCAN THE FORMS

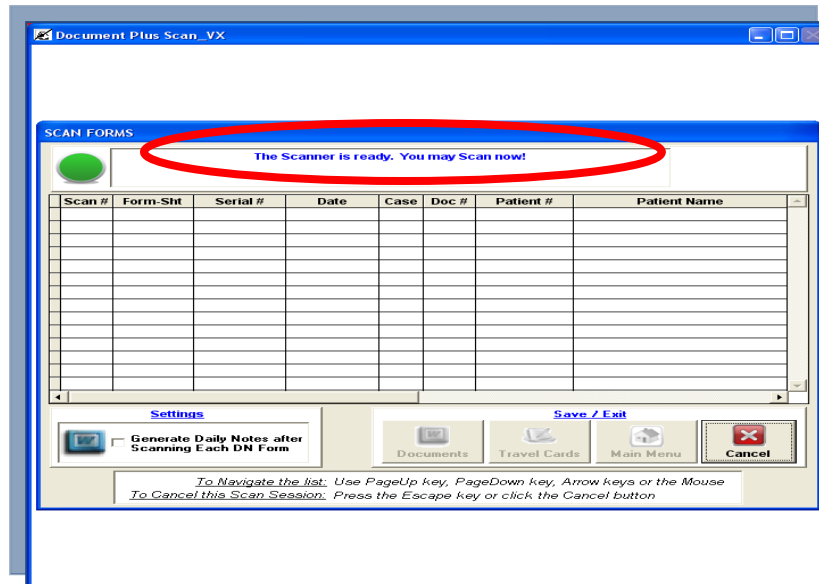
1. Click the “**Scan Forms**” button on the Main Menu. (see Figure 20 below)

Figure 20 – Main Menu



You are now in the “Forms Scanned” screen. (See Figure 21 below)

Figure 21 – Forms Scanned



NOTE: Once the scanner initializes, you will see a “**DocPlus Scanner Ready**” message in the upper right corner of your screen. **You are now ready to scan.**

2. Scan the forms that you have prepared. (HQ3, CE3, RD2) ([See Pg. 23 for correct form orientation](#))

NOTES: A. Your form has scanned successfully when you see it listed in the “Forms Scanned” window (Figure 22 below).

Figure 22 – Forms Scanned

The screenshot shows the 'Document Plus Scan_VX' application window. Inside, there's a 'SCAN FORMS' section with a status indicator (green circle) and the message 'The Scanner is ready. You may Scan now!'. Below this is a table listing scanned forms. A red oval highlights this table.

Scan #	Form-Sht	Serial #	Date	Case	Doc #	Patient #	Patient Name
1	HQ#3-1	422194	01/12/2012	0	1	3	Jones, Bob
2	HQ#3-2	422194	01/12/2012	0	1	3	Jones, Bob
3	CE#3-1	618572	01/12/2012	0	1	3	Jones, Bob
4	CE#3-2	618572	01/12/2012	0	1	3	Jones, Bob
5	CE#3-3	618572	01/12/2012	0	1	3	Jones, Bob
6	CE#3-4	618572	01/12/2012	0	1	3	Jones, Bob
7	RD#2-1	154001	01/12/2012	0	1	3	Jones, Bob

Below the table are buttons for 'Settings', 'Generate Daily Notes after Scanning Each DN Form', 'Documents', 'Travel Cards', 'Main Menu', and 'Cancel'. At the bottom, there's a note: 'To Navigate the list: Use PageUp key, PageDown key, Arrow keys or the Mouse. To Cancel this Scan Session: Press the Escape key or click the Cancel button.'

B. If you are getting a Validation WARNING (Figure 23A, below): Press any key to stop the beeping. Read the screen. You may choose to “Continue” past these and fix them later or correct the form, click “Re-scan” and scan the form(s) again.

Figure 23A – Validation WARNING

The screenshot shows the 'Document Plus Scan_VX' application window with a 'Scanned Forms: Validation WARNING' dialog box open. The dialog box contains the following information:

- Form: Health Questionnaire 3a
- Id: HQ3a Sht-1
- Case: 0
- Serial #: 422194
- Patient: Jones, Bob (Mr)
- Id: 3
- Visit Date: 01/12/2012

Below this information is a yellow box with the text 'Validation - WARNING'. At the bottom of the dialog box, there are three buttons: 'Re-Scan' (with a green circular arrow icon), 'Continue' (with a blue right-pointing arrow icon), and 'Print' (with a printer icon). A red oval highlights the 'Re-Scan' and 'Continue' buttons.

At the bottom of the main window, there's a note: 'To Navigate the list: Use PageUp key, PageDown key, Arrow keys or the Mouse. To Cancel this Scan Session: Press the Escape key or click the Cancel button.'

NOTE: Validation WARNING
You may “Continue” or fix and “Re-scan” the form.

C. If you are getting a **Validation ERROR** (Figure 23B, below): a. Press any key to stop the beeping and read the screen. Correct the errors on the form. Click **“Re-scan”** and scan the form(s) again.
REPEAT this process until you no longer see the **“Validation ERROR” screen.

Figure 23B – Validation ERROR

The screenshot shows the 'Document Plus Scan_VX' application window. Inside, there's a 'Scanned Forms: Validation ERROR' dialog box. The dialog box contains a table with the following data:

Form:	Id:	Case:	Serial #:
Clinical Evaluation	CE3a Sht-2	0	618572
Patient:	Id:	Visit Date:	
Jones, Bob (Mr)	3	01/12/2012	

Below the table, the text 'Validation - ERROR' is displayed. A red circle highlights this text. At the bottom of the dialog box, there are three buttons: 'Re-Scan' (with a circular arrow icon), 'Continue' (with a right arrow icon), and 'Print' (with a printer icon). The 'Re-Scan' button is circled in red. A note at the bottom of the window reads: 'To Navigate the list, Use PageUp key, PageDown key, Arrow keys or the Mouse To Cancel this Scan Session, Press the Escape key or click the Cancel button'.

NOTE: Validation ERROR
You must fix and “Re-scan” the form.

3. Once scanning is complete, press **“Enter”** on your keyboard and continue with **“Generating Documents”**. (Pg. 27)

STEP 3: GENERATING DOCUMENTS

Overview

- **Reports** – The summaries listed in this group, with the exception of “**Daily Notes**” and “**HMO Forms**”, are designed for in-office use.
- **Patient Letters** – These documents are excellent practice building tools. (see Pg.30-31)
 - The “**Initial Report Of Findings**” document is usually given to the patient on their report of findings visit.
 - The “**Welcome to the practice**” letter can be customized. “**Thank You**” letters may also be generated.
- **Consultation Note** – This is where you generate narratives for **Doctors, Insurance Companies, and Attorneys**. Also, see practice building ideas on Pg. 29.
- **Controls** – This section enables you to navigate within the program from the “**Generate Documents**” screen. Functions of each button are outlined on Pg. 31.

Figure 24 – Generate Documents

DocumentPlus(9.010A) - Document Generation (DOCUMENT.EXE) [WkSta:ServerActv]

Generate Documents: Jones, Bob (# 3)

Reports

- ☐ Initial Patient History
- ☐ Clinical Evaluation
- ☐ X-Ray Summary/Report
- ☐ Clinical Re-Evaluation
- ☐ Accident/Injury History
- ☐ Automobile Accident
- ☐ Daily Notes
- ☐ Outcome Measures
- ☐ HMO Forms
- ☐ Abbreviated Report

Signed By: ☒ Form ☐ Current

Consultation Note

Attorney Howe, Harry, Esq.

☐ Initial ☐ Re-Eval ☐ Final

Insurance Missing PRIMARY Insurance Co.

☐ Initial ☐ Re-Eval ☐ Final

Doctors Casey, Ben, M.D.

Referred From: ☐ Initial ☐ Re-Eval ☐ Final

Referred To: ☐ Initial ☐ Re-Eval ☐ Final

Personal Physician: ☒ Personal ☐ Initial ☐ Re-Eval ☐ Final

Signed By: Discipline

Initial: Your, Doctor, D.C.

Current: Your, Doctor, D.C.

Patient Letters

- ☐ Welcome To Practice
- ☐ Initial Report Of Findings

Controls

☐ Query Edit ☒ Dates Admin

Forms Active

CE3	01/12/12
HQ3	01/12/12
RD2	01/12/12

Towhom (c:\docplus9.010\vb\misc\towhom.dbf) Record: 6/37 Exclusive NUM 12:25:16

NOTE: See Page 37 for forms required to produce each document.

A. GENERATING DOCUMENTS – “REPORTS / SUMMARIES”

“Reports” Overview – With the exception of **“Daily Notes”** and **“HMO Forms”**, the documents listed under **“Reports”** appear in a bulleted summary format and are intended for in-office use.

Generate an **“Initial Patient History”**:

1. To select the summaries you want to generate click on the name of the document(s) under **“Reports”**. To de-select the document, click on the name again or click **“Clear”** under **“Controls”**.
2. For this tutorial, select **“Initial Patient History”**.
3. Click **“Generate”** under **“Controls”**. The system will now review the scanned forms for additional hand written information. The **“Information Written on Form”** or **“Query”** screen will appear (Fig. 25, Pg. 32). Refer to **“Queries”** (Pg. 32) for information on properly entering queries.
4. Once the queries have been entered, the **“Initial Patient History”** summary will be generated. When finished, you may exit the document.

- NOTES:**
- a. Reports you can generate are in bold letters. Those that are grayed out CANNOT be generated. Those forms have either not been scanned, have failed validation errors, or do not belong to the current case.
 - b. The information contained in the **“Initial Patient History”** summary comes from the initial Health Questionnaire (HQ) Form. This can be generated and printed for the doctor prior to seeing the patient.
 - c. When generating the **“Initial Patient History”** summary you may receive a validation warning when the patient has not properly filled in all the information on the HQ form. You may **“Continue”** past these errors. When the summary is printed, you will find a section at the end of the summary titled **“Corrections to Health Questionnaire”**. Simply give this section to your patient, have them answer the questions and return it to you. Correct and re-scan the form.

B. GENERATING DOCUMENTS – “CONSULTATION NOTES”

“Consultation Note” Overview – Consultation notes are comprehensive, professionally formatted narratives for your **Doctors** (“personal”, “referred to” and “referred from”), **Insurance Companies**, and **Attorneys**.

- NOTES:**
- A Health Questionnaire and a Clinical Evaluation are the minimum forms required to create a “case” in Document Plus.** Once a case is created you are able to generate Insurance, Doctor and Attorney narratives.
 - In the **“Consultation Note”** section on the **“Generate Documents”** screen, you will see three options under each heading (**“Initial”**, **“Re-Eval”**, and **“Final”**). The **“Initial”** report will include your initial findings. **“Re-Eval”** will include your re-evaluation findings. **“Final”** will include Initial and Final findings. (Daily Notes are not included in narratives and must be generated separately.)
 - Refer to the table on Pg. 37 for forms required to generate various reports.

Generate a narrative for a “Personal” physician:

- In the **“Consultation Note”** section under **“Doctor”**, select **“Personal”**, then check **“Initial”**.
- Click **“Generate”** under **“Controls”**. The **“Information Written on Form”** screen ([Figure 25, Pg. 32](#)) will appear.
- Once you have entered the queries, your personal physician’s narrative is generated automatically.
- Notice that the information you typed appears in blue. If you need to make changes to this text, refer to [Pg. 33, #4](#).
- Repeat the above steps to generate narratives for **“Referred To”** and **“Referred From”** physicians.

****Practice Building Ideas:**

- With your patients’ permission, send narratives to their primary care physicians. You will begin getting referrals from those physicians.
- Send narratives to **“Referred To”** physicians in advance.
- Send narratives to **“Referred From”** physicians thanking them for referrals.

Generate a narrative for an “Insurance” company:

1. In the “**Consultation Note**” section under “**Insurance**”, select “**Initial**”.
2. Make sure the insurance company associated with the selected patient appears in the field to the right of “**Insurance**”. If not, select the appropriate company from the drop down list.
3. Click “**Generate**” under “**Controls**”.
4. Your insurance narrative will generate automatically. Notice that the query screens do not appear. This is because you entered them when generating the previous narrative. To make changes to query text, refer to [Pg. 33, #4](#).

Generate a narrative for an “Attorney”:

NOTE: The attorney report will be generated as a PAST TENSE document. The query screens appear to insure that your document is grammatically correct.

1. In the “**Consultation Note**” section under “**Attorney**”, select “**Initial**”.
2. Make sure that the attorney associated with the selected patient appears in the field to the right of “**Attorney**”. If not, select the appropriate name from the drop down list.
3. Click “**Generate**” under “**Controls**”. The “**Information Written on Form**” screen ([Figure 25, Pg. 32](#)) will appear.
4. The text you entered previously appears in the “**Text hand written on form**” section. Check the grammar on these screens to insure that they are written in past tense.
5. Click “**Ok**” to advance through the queries.
6. When you have finished, your attorney narrative will generate automatically.

C. GENERATING DOCUMENTS – “PATIENT LETTERS”

“Patient Letters” Overview – Patient letters are excellent client retention and practice building tools.

“Welcome to the Practice” – You may generate a welcome letter for new patients. You can customize this letter to suit the specific needs of your practice.

“Thank You” – A “**Thank You**” letter can be generated for referring patients. You may generate a “**Thank You**” letter only if you have a “**referred from**” patient entered into the database.

“Initial Report of Findings” – Written in layman’s terms, this document is designed to educate the patient and encourage them to follow their long term care plan.

Generate an “Initial Report of Findings”:

1. For this tutorial, select **“Initial Report of Findings”** under **“Patient Letters”**.
2. Click **“Generate”**. Notice the simplicity of how the document is written.
3. When you have finished reviewing the document close the window to exit the document.

D. GENERATING DOCUMENTS – “CONTROLS”

“Controls” Overview – This section enables you to navigate within Document Plus from the **“Generate Documents”** screen.

- **Generate:** Allows you to generate any available documents. You may generate many documents simultaneously by selecting multiple documents before you click **“Generate”**.
- **Clear:** Clears ALL selected documents.
- **Forms:** View active and inactive forms or edit the date on forms scanned for the selected patient.
- **Patients:** Allows you to select a different patient with forms on file from your patient database.
- **Records:** View, edit, and print scanned images for the selected patient.
- **Main Menu:** Return to the Main Menu.
- **Query Edit:** When selected, this feature allows you to edit previously entered query information.
- **Dates Administered:** When selected, the system will select the proper Outcome Assessment forms associated with the selected patient’s case.

QUERIES

Overview

When specific information cannot be indicated with existing bubbles it must be hand written onto the form. There are several areas on each form where additional information can be written. When the bubble associated with one of these areas is bubbled and the form is scanned the **"Information Written on Form"**, or **"Query"** screen appears. (Figure 25 below) The hand written information is entered into the system using these query screens.

A. COMPLETING THE QUERY SCREENS

1. **Locate the origin of the query.** - In the **"Information Written on Form"** screen, the upper portion of the window contains a description of where on the form the question originated from (i.e. the form type, the page number and location). (see Figure 25 below) Find the question on your form. (section B1, HQ3 form)
2. **Enter the query.** - In the **"Explanation"** box an explanation and example will be provided, advising you how to properly enter the query (i.e. with a full sentence or by typing one word entries). Type your entry into the **"Text Hand Written on Form"** field at the bottom of the screen. (See Figure 25 below).

Figure 25 – "Information Written On Form" screen

The screenshot shows a software window titled "Information Written On Form" with a status bar at the top indicating "WAIT... Generating: - Patient History Summary [HQ-3]". The window is divided into several sections:

- Top Section:** Contains fields for Patient information: Patient: Jones, Bob (Mr.), Id #: 3, Document: Records - Summary Initial Patient History, Form: Health Questionnaire 3, Serial #: 422194, Date: 01/12/2011, Pg: HQ3 Pg.1, Version: 3a, Location: B1, and Bubble Text: Date, Spinal(Neck/Back/Ribs) Complaints Began.
- Explanation Section:** Contains the text "Patient's Complaints - When Did Your Neck/Back Complaints Begin - Date", "Enter the date complaints began", "Symptoms Began: --/--/--", and an example: "Example: Symptoms Began: 04/30/2001."
- Text Entry Section:** Includes a "Predefined:" dropdown menu, a "Text Hand Written On Form:" field with the value "Missing", and a "Query Source:" field with the value "12/12/2011".
- Buttons:** At the bottom are buttons for "Ok", "Clear", "Delete", "Restore", "Skip", "Ok / Skip Rest", and "Query Edit".

Callouts with red arrows point to specific elements:

- Location on Form:** Points to the "Location: B1" field.
- Page Number:** Points to the "Pg: HQ3 Pg.1" field.
- Explanation and Example:** Points to the "Explanation" section.
- Text Hand Written on Form:** Points to the "Text Hand Written On Form:" field.

3. **Once you have finished –**

Click **"OK"**, and the next query to be entered will appear. Once you have entered a query it will not come up again automatically the next time you generate a document.

Click **“Skip”**, and the query will be skipped until the next time you generate the document. **NOTE:** This will appear as a skipped query in your document.

Click **“Clear”** if you have entered something in error and want to make changes while you are still in the **“Information Written on Form”** screen.

Click **“Restore”** and the cleared information will be restored.

NOTE: When an **“EMPTY”** button replaces the **“OK”** button you have the option of NOT entering questions that are not pertinent to generating a narrative. If you select **“EMPTY”**, that query will not appear in your document.

4. **To change a previously entered query** - Click in the **“Query Edit”** box in the **“Generate Documents”** screen (See Fig. 26 below). All queries will be presented again. Click **“OK”** or **“Empty”** until you see the one you wish to change. Edit the query and click **“OK”**. If you do not need to make any more changes click **“OK, Skip Rest”**.

Figure 26 – Generate Documents – Query Edit

B. CUSTOMIZING QUERIES

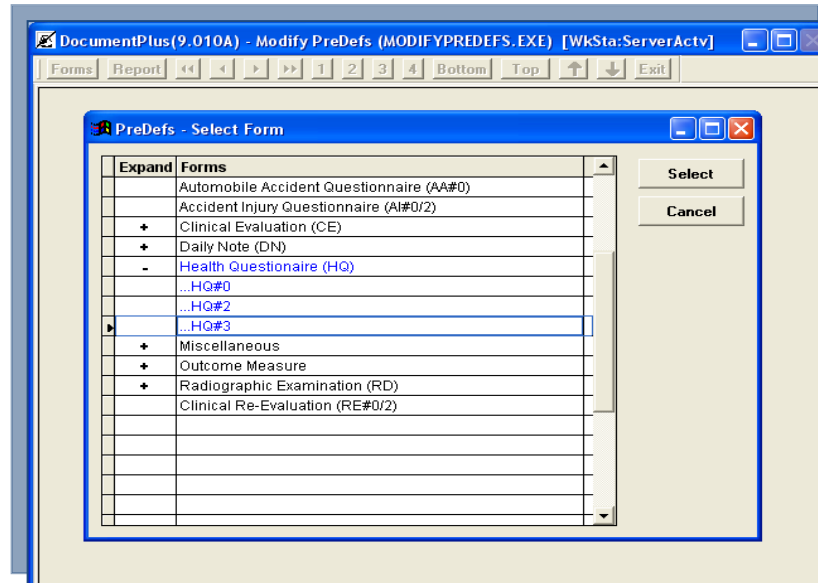
Overview

When you find that you are typing the same query entries for multiple patients, you may want to consider customizing the queries. This process saves data entry time by allowing you to either predefine entries into specific bubbles or create “pick lists” of multiple items to choose from.

1. From the Main Menu of Document Plus, click **“Utilities”**
2. Select **“Modify Predefines”**.

You are now in the **“PreDefs – Select Form”** screen. (Figure 27 below)

Figure 27 – “PreDefs – Select Form” screen



We will now customize a bubble on the Health Questionnaire form (HQ3).

1. Select **“Health Questionnaire”**, then double click on **“HQ#3”** or highlight **“HQ#3”** and click **“Select”**.

An image of the **Health Questionnaire #3** now appears on your screen. (Figure 28 below)

Figure 28 – “Modify PreDefs” - Image of Health Questionnaire Form

1. On your screen, locate **Pg. 3, Section G, Question 1f. “Are you currently taking any Vitamins, Minerals, or Herbs?”** We will create a “pick list” of common supplements to choose from when entering this query.

NOTE: Use the left/right arrows at the top of your screen to navigate from page to page, and the up/down arrows on the right to scroll from top to bottom.



2. Click the “Yes” bubble for question **G1f**.

You will see the “**Modify PreDefs**” screen. (Figure 29 below)

Figure 29 – “Modify PreDefs” – G1(f)

3. Click “Add” and type “**echinacea**”.
4. Click “Add” and type “**glucosamine**”.
5. Click “Add” and type “**multivitamins**”.
6. Click “Add” and type “**chondroitin**”.
7. Highlight “**chondroitin**” and use the “**Move Item in List**” up arrow to arrange it alphabetically at the beginning of the list.
8. Click “Close / Save” at the bottom of this screen.

We will customize another bubble on the Health Questionnaire form (HQ3).

1. Scroll down to find **Pg. 3, Section G, Question 1h. “Are you allergic to any medications?”**
2. Click the “Yes” bubble to select question **G1h**.

The “**Modify PreDefs**” screen appears (Figure 30 below).

Figure 30 – “Modify PreDefs” – G1(h)

3. Click “Add” and type “aspirin”.
4. Click “Add” and type “codeine”.
5. Click “Add” and type “penicillin”.
6. Click “Add” and type “morphine”.
7. Highlight “morphine” and use the “Move Item in List” up arrow to arrange it alphabetically between “codeine” and “penicillin”.
8. Click “Close / Save” at the bottom of this screen.

NOTES: a. You may list up to 99 different items in each predefined bubble

- a. You may select the “Always Use” box for any predefined item. When the associated bubble is bubbled on the form, you will not have to enter a query regarding the item and it will always appear in your reports automatically.

- b. Delete an item from a list by highlighting it and clicking the “Delete” button at the bottom of the screen

- c. Click the “Report Location” button to print a list of all predefines entered for a particular query.

- d. Click the “Report” button in the upper left corner of the “Modify PreDefs” screen to print a list of all predefines for the selected form.

REPORTS

Refer to the tables below to determine which forms are required for each report.

Summaries:

REPORT	REQUIRED FORMS
Initial Patient History	Health Questionnaire (HQ#0b,HQ#2,HQ#3)
Clinical Evaluation	Clinical Evaluation (CE#2,CE#3a)
Radiographic Diagnosis	Radiographic Diagnosis (RD#0,RD#2)
Clinical Re-Evaluation	Clinical Re-Evaluation (RE#2,CE/RE#3)
Accident/Injury History	Accident/Injury Questionnaire (AI#2)
Automobile Accident	Automobile Accident Questionnaire (AA#0a)
Daily Notes	Daily Notes (DN#2a,DN#3c,DN#4)
Outcome Measures	Roland Morris Acute Low Back Pain Disability Questionnaire (RM) Revised Oswestry Low Back Pain Disability Questionnaire (RO) Health Status Questionnaire (HSQ) Neck Pain Disability Index Questionnaire (NP)

Patient Letters:

REPORT	REQUIRED FORMS
Welcome To Practice	HQ
Thank You For Referral	HQ (with a referring patient selected)
Initial Report of Findings	HQ and CE

Consultation Notes:

Attorney and Insurance

REPORT	REQUIRED FORMS
Initial	HQ, CE
Re-Evaluation	RE
Final	HQ, CE, RE
HMO	HQ#3 and CE#3

Doctors

REPORT	REQUIRED FORMS
Initial	HQ, CE
Re-Evaluation	RE
Final	HQ, CE, RE

Section C: DocumentPlus Tutorial II

“Daily Note/Travel Card”

DAILY NOTE and TRAVEL CARD SYSTEM

Introduction

The “Daily Note/Travel Card” will replace your existing travel card. It can be customized to accommodate your practice protocol, provides the ability of viewing the five most recent visits, and is designed to meet Managed Care and Medicare Guidelines. Features have been added that allow you to customize the form to fit your needs. This “Daily Note/Travel Card” system surpasses anything else currently available.

This tutorial was designed to give you an understanding of how the daily note and travel card system works and how it can be fully utilized in your practice. If you have completed Tutorial I you are ready to proceed. If you need further assistance after completing Tutorial II, please call 800-642-0600 to schedule a training session.

Overview

The first time you treat a patient you will fill out a daily note form (DN3c) in its entirety. The form is scanned and the information is saved in Document Plus. When the patient comes in for a second visit the information from the previous visit is printed onto a BLANK daily note form. That daily note form then becomes a travel card which you will use for that day’s visit.

What you will need

THREE (3) BLANK DAILY NOTE FORMS (DN3c)

#2 PENCILS

The image shows a sample of the DN3c form for a patient named Jones, Bob (#3). The form includes fields for patient demographics, a history of present illness, and a detailed section for today's treatment. The treatment section is organized by body region (Cervical, Thoracic, Lumbar, Sacral, Pelvic, Ankle, etc.) and lists various manual therapy techniques and procedures with checkboxes for documentation. The form is designed to be filled out by a healthcare provider and then scanned into the Document Plus system.

STEP 1: Filling out the Daily Note Form (DN3c) – INITIAL VISIT

We will now fill out a Daily Note form for Bob Jones' (patient #3) first visit.

[Use a #2 pencil when bubbling information onto the form.]

DATE, DR#, PATIENT NUMBER	
DATE	DR#, PATIENT NUMBER

1. Using Figure 1(below) as a guideline, fill in a date on your form at least TWO days prior to today's date.
2. Bubble **Doctor #1** and **Patient #3** onto your form as shown in Figure 1 (below)

Figure 1 – Date, Doctor Number, Patient Number (Page 1, Upper Right, DN3c Form)

Patient Name:

MO	DAY	YR
2	2	8

SAT Except:

P	SLIP	A
1	N	O

NOTES: a. This section must be completed for each visit.

b. Please note that in the “**DAY**” column the top section of bubbles reflect units of ten and the bottom numbers reflect units of one.

c. In the year column (“YR”) it is only necessary to bubble the one or two digits representing the year. 2000 is assumed. (e.g. If the year is **2008**, only the “**8**” should be bubbled.)

d. In the “**DR#**” and “**Patient Number**” sections, the numbers should be bubbled in columns farthest to the right.

SYMPTOMS	
1	1.1
2	2.1
3	3.1
4	4.1
5	5.1
6	6.1
7	7.1
8	8.1
9	9.1
10	10.1
11	11.1
12	12.1
13	13.1
14	14.1
15	15.1
16	16.1
17	17.1
18	18.1
19	19.1
20	20.1
21	21.1
22	22.1
23	23.1
24	24.1
25	25.1
26	26.1
27	27.1
28	28.1
29	29.1
30	30.1
31	31.1
32	32.1
33	33.1
34	34.1
35	35.1
36	36.1
37	37.1
38	38.1
39	39.1
40	40.1
41	41.1
42	42.1
43	43.1
44	44.1
45	45.1
46	46.1
47	47.1
48	48.1
49	49.1
50	50.1
51	51.1
52	52.1
53	53.1
54	54.1
55	55.1
56	56.1
57	57.1
58	58.1
59	59.1
60	60.1
61	61.1
62	62.1
63	63.1
64	64.1
65	65.1
66	66.1
67	67.1
68	68.1
69	69.1
70	70.1
71	71.1
72	72.1
73	73.1
74	74.1
75	75.1
76	76.1
77	77.1
78	78.1
79	79.1
80	80.1
81	81.1
82	82.1
83	83.1
84	84.1
85	85.1
86	86.1
87	87.1
88	88.1
89	89.1
90	90.1
91	91.1
92	92.1
93	93.1
94	94.1
95	95.1
96	96.1
97	97.1
98	98.1
99	99.1
100	100.1

The information from this section on the form makes up the SUBJECTIVE portion of your DAILY NOTE report.

“Symptoms, Section I”

This section details the current symptoms the patient is experiencing and can be completed by the patient, staff or doctor. Fill in as much or as little as is applicable to the case.

3. Turn the form to Page 2. Locate “**Symptoms, Section I**”. (see Figure 2 below)
4. Locate “**RIGHT SIDE**” on your form. Drop down to the “**Neck**” area and bubble the symptoms as shown in Figure 2 (below). When complete, you should have bubbled (from left to right) “**Pain**”, “**Stiffness**”, “**Soreness**”, “**Severe**”, “**Sharp**”, “**Shooting**”, “**Frequent**”, and “**Unchanged**”.
5. Do the same for the “**LEFT SIDE**” of the “**Neck**”.

Figure 2 – “Symptoms, Section I” (Page 2, Upper Left, DN3c Form)

SYMPTOMS

SECTION I

RIGHT SIDE

Head
Neck
Upr Back
Mid Back
Low Back
Shoulder
Elbow
Wrist
Hand
Hip
Knee
Ankle
Foot

Pain Numbness Tingling Stiffness Soreness Swelling Weakness Mild Moderate Severe Burning Dull Sharp Shooting Stinging Throbbing Occasional Intermittent Frequent Constant Improving Worsening Unchanged Resolved

LEFT SIDE

Head
Neck
Upr Back
Mid Back
Low Back
Shoulder
Elbow
Wrist
Hand
Hip
Knee
Ankle
Foot

Pain Numbness Tingling Stiffness Soreness Swelling Weakness Mild Moderate Severe Burning Dull Sharp Shooting Stinging Throbbing Occasional Intermittent Frequent Constant Improving Worsening Unchanged Resolved

NOTE: The third column in “**Symptoms, Section 1**” reflects CHARACTERISTICS OF PAIN. If you have anything bubbled in this column you MUST bubble “**Pain**” in the first column. Not doing this will cause errors to appear when you scan the form. “**Pain**” can be bubbled and stand alone without any further descriptors.

“Symptoms, Section II”

In this section, the patient indicates pain rating, time of day symptoms are worse, fills in the pain diagrams, and indicates whether or not a new injury exists. The patient then signs and dates the form in the space provided. All of this appears in your daily note and should be filled out by the patient on each visit. There are items in this section that can be user defined.

“How would you rate your pain today...” – This is your Visual Analog Scale. The scale will reflect an overall pain rating from the patient’s perspective.

“If your symptoms change, when are they worse” – In this section the patient can bubble any or all applicable times of day. The **“Other”** bubble can be predefined for other circumstances that may aggravate a condition (such as “when bending”, “when lifting”, or “before getting out of bed”).

“Pain Diagrams” – In the Pain Diagram you may want to have the patient mark the area in which they are experiencing pain, rate the pain intensity (using a scale of 1-10), and even write in the percentage of the day they are experiencing that degree of pain in a particular area. An image of the completed Pain Diagram will appear in your daily note report. (See [Figure 3B, Pg. 42](#)) To have the following sentence appear in the **“Subjective”** section of ALL daily note reports select **“Pain Diagram Instructions”** under the **“Daily Notes 2”** tab in **“Setup”**. *“The patient was instructed to fill out the Pain Diagrams indicating each body area they experience pain. He was also shown how to place a number that specifies the level of pain and percentage of the day that pain occurs.”* If you use this sentence, make sure that the patient has been instructed to fill in the pain diagrams in a way that is consistent with the instructions indicated in the sentence. This sentence can be customized in the **“Modify Predefines”** screen for **“DN#3”**.

“No New Aggravation/Injury” – This statement references the initial clinical evaluation and by marking this bubble you are basically stating that there has been no change regarding injuries since the initial evaluation.

“New Injury” – This bubble should be marked when a new injury or an exacerbation of an old injury occurs. **“New Injury”** should be used in conjunction with **“New Additional”** in the **“Assessment”** section so that both new injury information and new diagnosis codes are documented.

“Signature” and “Date” – To provide proof that the patient was in the office, did receive treatment, and that the symptom information is accurate, the patient should provide a signature and date in this section on each visit. An image of the signature and date will appear in your daily notes. (shown in [Figure 3B, Pg. 42](#))

6. Locate **“Symptoms, Section II”** on your form. (See [Figure 3A, Pg. 42](#))
7. Bubble **“8”** in the pain scale as shown below in [Figure 3A, Pg. 42](#).
8. Bubble **“Morning”** for the question **“If your symptoms change, when are they worse?”**
9. Copy the information from [Figure 3B, Pg. 42](#) to the **“Pain Diagrams”** section on your form.

Figures 3A, 3B – “Symptoms, Section II” (Page 2, Upper Right, DN3c Form)

SECTION II
How Would You Rate Your Pain Today With 0 Being The Best And 10 Being The Worst

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Possible

If Your Symptoms Change, When Are They Worse

☒ Morning ☐ Evening ☐ Afternoon
☐ Night ☐ Other

PAIN DIAGRAMS Please Mark The Location Of Your Pain On These Figures

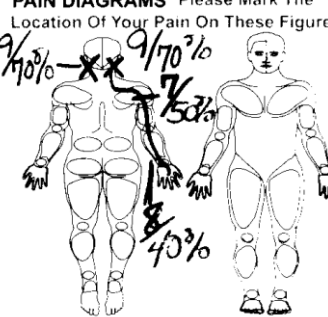


☒ No New Aggravation / Injury
☐ New Injury

PATIENT SIGNATURE: _____ DATE: _____

Figure 3A

PAIN DIAGRAMS Please Mark The Location Of Your Pain On These Figures



PATIENT SIGNATURE: *Bob Jones* DATE: *1-31-08*

Figure 3B

ASSESSMENT

The “**Diagnosis**” and “**Progress**” sections make up the ASSESSMENT portion of your Daily Note report. If you do not bubble anything here you will NOT have an “**Assessment**” section in your daily notes.

“Assessment, Diagnosis”

The diagnosis section references the Clinical Evaluation that is done on the patient’s initial visit.

10. Locate “**Assessment, Diagnosis**” on your form. (see Figure 4 below)

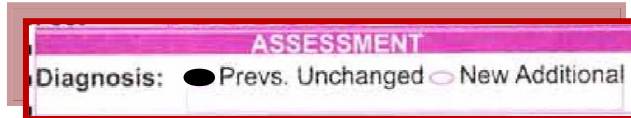
“**Previous Unchanged**” – When bubbled, you are basically noting that there have been no changes in diagnosis since the initial examination.

“**New Additional**” – When a new injury or exacerbation of an old injury occurs, you will want to bubble “**New Additional**” to document the additional diagnoses in the daily note. When bubbled, once the form is scanned, a query screen will appear so that you may choose the new diagnosis codes from a predefined list. This will remove the old diagnoses from the travel card and document the new.

“**Previous Unchanged**” + “**New Additional**” – When **both** of these are bubbled simultaneously the “**New Additional**” diagnosis codes will be added in front of the existing diagnoses and will be reflected in your daily notes.

11. Bubble “**Prevs. Unchanged**” as shown below in Figure 4.

Figure 4 – Assessment Section, “Diagnosis” (Page 2, Left, DN3c Form)



“Assessment, Progress”

Progress is documented here and references the initial visit.

12. Locate “**Assessment, Progress**” on your form. (see Figure 5 below)

“**Progress**” – Use this section as needed.

“**Response to Treatment in %**” - Allows you to enter the patient's progress in terms of percentage of reduced spasm, tenderness, inflammation, and also in terms of increased mobility and activities of daily living. The “**other**”: feature may be used to document an increase (e.g. increase in work ability) or a decrease (e.g. decrease in hypertonicity). “**0**” percent indicates no improvement and “**100**” indicates 100% improvement and refers to the patient’s condition at the time of the initial visit. The previous responses to treatment will appear in the “**TxResp**” section of the travel card for easy reference.

Figure 5 – Assessment Section, “Progress” (Page 2, right, DN3c Form)



13. Skip the progress section if the patient has no initial visit and there is no

PLAN

14. Locate **“Plan”** on your form. (see Figure 6 below)

“Changed As follows” – When bubbled, the **“Information Hand Written on Form”** screen will appear allowing for the doctor’s notes to be typed in. You may use this bubble by itself or in addition to **“Per Initial/Prev. Plan”**.

“Additional Recommendations” – Use this section if you wish to document additional recommendations for further examination.

“Visit Schedule” – Use this section to document a patient’s visit schedule. You may only bubble one item in the first row. (**“Daily”, “Weekly”, “Monthly”, “PRN”**) **“PRN”** can be user defined. When it is bubbled a query screen will appear. The **“Visits this Plan”** section is used to document the total number of visits in the current treatment plan.

15. You want to see Bob 3 times per week for 4 weeks (a total of 12 visits). Under “**Visit Schedule**” bubble the “**3**” next to “**Weekly**”. Then, to the right of “**Visits This Plan**” bubble the “**10**” and the “**2**” (12 visits). (shown below in Figure 6)

Plan” Section (Page 2, Right, DN3c Form)

PLAN	
☐ Per Initial/Prev. Plan ☐ Changed As Follows:	
Additional Recommendations ☐ Observation ☐ Re-Exam ☐ X-Ray ☐ Other ☐ Add'l. Diagnostic Testing	Home Care Instructions ☐ Rest ☐ Moist Heat ☒ Ice ☐ Gen. Measures ☐ Exercise ☐ Other
Visit Schedule	
Daily ☐ 1 ☐ 2 Weekly ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Monthly ☐ 1 ☐ 2 ☐ PRN Visits This Plan ☒ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9	
Exam ☐ New Patient ☐ Established ☐ Established/TX ☐ Consultation	
☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V	

“TODAYS TREATMENT, Modalities”

The information from this section appears as part of the TREATMENT portion in your daily note report. Mark only the modalities that were performed. There are three "**other**" bubbles in this section. These bubbles can be user defined for any modalities used in your office and not listed across the top of this section.

You also have the option to specify if the treatment was attended, and for how long. If you do not wish to mark a treatment as attended, simply leave the “**Attend**” bubble empty. You may bubble multiple time increments for therapies lasting longer than 30 minutes. The system will add them together automatically. (e.g. If massage was performed for 1 hour you would bubble “**30**”, “**15**”, “**10**”, and “**5**”)

17. Locate **“Today’s Treatment, Modalities”** on your form. (see Figure 7 below)
18. Draw a heavy line down through the **upper (U), middle (M), and lower (L) cervical area** under the **“Ice”** column. (shown below in Figure 7)
19. Drop down to the time increments in the **“Ice”** column and bubble **“15 min”**.
20. Draw a heavy line down through the **upper, middle, and lower cervical area** under the **“Other 3”** column.
21. Drop down to the time increments in the **“Other 3”** column and bubble **“10 min”**. (We will predefine this bubble with another modality prior to scanning the form.)

Figure 7 – “Today’s Treatment, Modalities” Section (Page 2, Lower Left, DN3c Form)

[illegible]

REHAB THERAPY

The information from this section appears as part of the TREATMENT portion in your daily note report. This entire section is user defined. If you do not predefine the therapies, a query screen will appear when you scan the form and you must enter the information each time.

22. Locate **“Rehab Therapy”** on your form. (see Figure 8 below)
23. Bubble **“10”** in the **“cervical”** column as shown in Figure 8 below.

Figure 8 – “Rehab Therapy” Section (Page 2, Bottom, DN3c Form)

	Cervical	Shoulder	Low Back	Abdominal	Multipelvic Hip	Elbow	Wrist	Knee	Bike	Treadmill	Exercise Tubing	Exercise Ball	Other
5	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
10	(●)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
15	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
20	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
25	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
30	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
35	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
40	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
45	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
50	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
55	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
60	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
65	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
70	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
75	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
80	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
85	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
90	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
95	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
100	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)

MAN/ADJ (Manipulations/Adjustments)

This section is used primarily for billing purposes. The information, with the exception of the treatment codes and the case numbers, will appear as part of the PLAN section in your daily note report. There are items in this section that can be predefined.

24. Locate “**Man/Adj.**” on your form. ([see Figure 9, Pg. 48](#))

“**Treatment Codes**” –When one of these Tx Codes is bubbled (98940,98941,98942, or 98943), the **number of regions adjusted** will be compared to the **number of subluxations** marked in the “**Biomechanical Exam**” portion of the “**Objective**” section on the daily note. If you choose a code that does not compare, a “**Validation WARNING**” will prompt you to make the necessary corrections to either the billing code or the number of spinal segments treated. You have the option to click “**Continue**” past this warning so it will accept the code you have chosen. If you are using this section for billing purposes you will want to bubble the appropriate treatment code in this section. If you do not have an interfaced billing software, you can simply leave this section blank if you choose.

The following is a chart of the “**Man/Adj.**” section requirements. These codes compare the regions adjusted with the number of subluxations marked in the “**Objective**” section on the “**DN3c**” form.

98940	Bubble 1 to 2 spinal regions in the “ Objective ” section.
98941	Bubble 3 to 4 spinal regions/subluxations
98942	Bubble all 5 spinal regions
98943	Bubble extremity only

“**Case Numbers**” – The 5 case number bubbles serve only to designate a different case number for an existing patient. The default case number is “0”. The first time you assign a case number to a patient using this section, use case number “1”. **If you have a billing software that is interfaced with Document Plus, call before using this feature.** Examples of when you might assign a case number to a patient are listed below:

- a. A patient has not been active for a long period of time, and then decides to return for care.
- b. If a patient, while under an existing treatment plan, has an accident and becomes a personal injury case.

“**Pillows**” – In this section you may predefine different types of therapeutic or support pillows. This section appears as part of the “**Plan**” section in your daily note report and will be preceded by “**The following was prescribed**” or followed by “**was prescribed**”.

“**Orthotics**”- When bubbled, “**Orthotics**” will be preceded by “**The following was prescribed**” or followed by “**was prescribed**” in the “**Plan**” section of your daily note report.

“**Ice Pack**” – When bubbled, “**Ice Pack**” will be preceded by “**The following was prescribed**” or followed by “**was prescribed**” in the “**Plan**” section of your daily note report.

“**1-6 Bubbles**” – These bubbles are user defined. You may add up to 99 different items into each bubble. These will appear in the “**Plan**” section of your daily note report and will be preceded by “**The following was prescribed**” or followed by “**was prescribed**”. This is an ideal place to list nutritional supplements.

- Figure 9 – “Man/Adj” Section (Page 2, Bottom, DN3c Form)**

48

X-RAYS

The “**X-Rays**” section is to be used as a billing tool for your x-rays. If this daily note is to be used in conjunction with a billing system, and is filled out for the first visit, you will mark all of the x-rays taken. This section can be used when you take additional x-rays or re-takes. The x-ray information will also appear in your daily notes. There are items in this section that can be predefined.

26. Locate “**X-Rays**” on your form. (see Figure 10 below) **NOTE:** For this tutorial, we will not bubble anything in the X-Ray section.

Figure 10 – “X-Rays” Section (Page 2, Lower Right, DN3c Form)



The image shows a close-up of the 'X-Rays' section of a form. The title 'X-Rays' is at the top in a pink box. Below it is a list of x-ray types, each preceded by an empty oval bubble for marking. The items are: Full Spine A-P, Cerv A-P/Lat, Thor A-P/Lat, Lum A-P/Lat, Lum Compl, Cerv Dav Ser, Cerv Compl, S View 14X17, S View 10X12, and a final empty bubble with a line for additional entries.

X-Rays
☐ Full Spine A-P
☐ Cerv A-P/Lat
☐ Thor A-P/Lat
☐ Lum A-P/Lat
☐ Lum Compl
☐ Cerv Dav Ser
☐ Cerv Compl
☐ S View 14X17
☐ S View 10X12
☐ _____

OBJECTIVE

The information from this section makes up the OBJECTIVE portion in your daily note reports.

“Leg Length Deficiency” – This section is used to document asymmetry.

“Biomechanical Exam” – This is the section the doctor will use to document examination findings for that day’s visit.

NOTE: If **“RADIATE”** is bubbled, **“TENDER”** must also be bubbled. (TENDER may be bubbled without RADIATE)

(When **“Radiate”** is marked in the cervical, thoracic, or lumbar region, an option exists to designate to what area of the body tenderness is radiating to. **(For example:** If **“Radiate”** is marked in the thoracic region and upper extremities are also marked, the conclusion is that the condition radiates into the upper extremities.)

(**“Radiate”** can be bubbled without a “radiate to” location. The text would simply state that the tenderness radiates. The sacral and pelvic regions can radiate downward into the lower extremities, but do not radiate upward.)

“Posture” – This section is used to document postural deviations.

“Forward Flexion” – Forward Flexion can be documented in the cervical, lumbar, or both.

“Range of Motion” - When **“Decreased”** range of motion is bubbled you must indicate the level of pain associated with that area [**“Mild (+)”**, **“Moderate (++)”**, or **“Severe (+++)”**].

27. Turn to Page 1 and locate the **“Objective”** section on your form. (See Figure 11, Pg. 51)

28. In the **“Leg Length Deficiency”** section, bubble **“Right 1/8”**. (shown in Figure 11, Pg. 51)

29. In the **“Biomechanical Exam”** section: Bubble the following areas as shown in [Figure 11, Pg. 51](#).

- a. On the **LEFT** side in the **CERVICAL** area, draw a heavy line down through **upper (U)**, **Middle (M)**, and **lower (L)** in the **“Sublux”** and **“Spasm”** columns.
- b. On the **RIGHT** side in the **CERVICAL** area, draw a heavy line down through **upper (U)**, **middle (M)**, and **lower (L)** in the **“Sublux”**, **“Spasm”**, **“Tender”**, **“Inflammation”** and **“Radiate”** columns.
- c. To indicate where the cervical pain on the right side is radiating to, locate the **right upper extremity** area (**“U Ext”**) on your form. Bubble **“Tender”** and **“Inflammation”**.

30. Under **“Posture”**, bubble **“R, Head Tilt”**.

31. Under **“Forward Flexion”**, bubble **“Cervical”**.

32. In the **“Range of Motion”** section, in the **“Cervical”** area, bubble **“Decreased”** and **“Severe”**.

Figure 11 – “Objective” Section (Page 1, Upper Left, DN3c Form)

[illegible]

THRUST REPORT

Located on the right side of Page 1 is an area called the “**Thrust Report**”. This section is used to document the primary adjustment technique by listing. Adjustments documented in this section will appear as part of the TREATMENT portion in your daily note reports. There are items in this section that can be predefined.

33. Locate the “**Thrust Report**” on your form. (see Figure 12 below)
34. Locate the **technique bar** slightly to the left of the TMJ box. (shown in Figure 12 below)
35. Bubble “**Inst.**” (instrument)
36. In “**Occiput**”, bubble “**POS**” in the top right corner (right posterior).
37. In “**C2**”, bubble “**A**” (anterior)
38. In “**C3**”, bubble “**R**” (right)
39. In “**C7**”, bubble “**R**” and “**SUP**” (right and superior)

NOTE: If nothing is bubbled in the technique bar it will automatically default to “**instrument**”.

Figure 12 – “Thrust Report” Section (Page 1, Right, DN3c Form)

NOTE: Use of the “**Thrust Report**” section of the form is not required. You have the option of solely using the “**Today’s Tx, General Listings**” section in the lower left corner of Pg. 1. If the “**Thrust Report**” section is used, it will be listed first in your daily note reports. If only the “**Today’s Tx, General Listings**” section is used, “**Tx1**” will appear first.

The image shows a portion of the DN3c Form, specifically the 'Thrust Report' section. It features a 'Technique Bar' and a 'Cervical Area'. The 'Technique Bar' is a horizontal row of bubbles labeled 'Inst.', 'Pos', 'Ant', and 'Sup'. The 'Cervical Area' is a vertical column of bubbles labeled 'Occiput', 'Atlas', 'C2', 'C3', 'C4', 'C5', 'C6', and 'C7'. Each of these labels has a grid of bubbles for recording techniques. To the left of the 'Cervical Area' is a vertical column of bubbles labeled 'T1' through 'T12'. A callout box on the left explains that the 'Thrust Report' section is optional and will be listed first in daily note reports if used. Arrows point from the 'Technique Bar' and 'Cervical Area' labels to their respective sections on the form.

TODAY'S Tx – GENERAL LISTINGS

The “**Today’s Tx – General Listings**” section is used to document the treatment rendered on each visit and appears as part of the TREATMENT portion in your daily notes report. There are items in this section that can be predefined.

40. Locate “**Today’s Tx – General Listings**” on your form. (See Figure 13 below)

Notice that in this section there is a “**Tx1**” and a “**Tx2**” section. This feature enables documentation of two techniques **in addition to** what was recorded in the “**Thrust Report**” ([Page 52](#)). In this section, you also have columns in which you are able to document adjustments to the upper and lower extremities. Each extremity column has a separate technique bar.

41. Locate the technique bar in the “**Tx1**” section. (shown in Figure 13 below)

42. Bubble “**MM**” (manual manipulation)

43. Bubble “**5**” and “**6**” in the cervical area under “**Tx1**”.

44. In the “**Upper Extremity**” column, bubble “**Inst.**”

45. In the “**R**” column, bubble “**Wrist**”.

46. Bubble “**Y**” next to “**Patient Tolerated Procedure Well**”. This is considered a risk management item and should always be marked. When marked, a sentence will appear in your daily note report stating that there has been no problem with treatment up to this point.

Figure 13 – “Today’s Tx – General Listings” Section (Page 1, Lower Left, DN3c Form)

TODAY'S TX-General Listings

Tx1

Inst MM FLD 2 3

C C1 C2 C3 C4 C5 C6 C7 10 11 12

T T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

L L1 L2 L3 L4 L5 Sacrum Pelvis

Tx2

Inst MM FLD 2 3

C C1 C2 C3 C4 C5 C6 C7 10 11 12

T T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

L L1 L2 L3 L4 L5 Sacrum Pelvis

Inst MM R L

AC Joint Foot

Clavicle Patella

Elbow Coccyx

Wrist Psoas

Hand

Thumb

Patient Tolerated Procedure Well

Technique Bar

Technique Bar

The “Tx1” section should be used before using “Tx2”

SOAPT - Of Additional Note

In the lower left corner of Pg. 1 on your form is a section labeled “**SOAPT**” (1 & 2). The “**SOAPT**” bubbles are used to insert information into your notes when there is no other available bubble on the form. If one of these bubbles is marked, a query screen will prompt you to type in any additional notes. You have the option of entering the information each time or predefining these bubbles.

By default, “**SOAPT 1**” bubbles will appear only in your daily note report. Information entered using the “**SOAPT 1**” bubbles will appear as a complete sentence or sentences in the corresponding section. (e.g. If “**S1**” is bubbled the information will appear in the “**Subjective**” section in your notes.)

By default, information entered using the “**SOAPT 2**” bubbles will appear only in the “**notes**” section on your travel card (used for in-office information). The default settings can be changed in “**Setup, Daily Notes 1**” so that the “**SOAPT 2**” bubbles appear in your daily note reports and not in the travel card. ([See “Advanced Setup”, Pg. 72-78](#))

47. Locate “**SOAPT**” (1 & 2) on your form. (See Figure 14 below) These bubbles can be found in the lower left corner of page 1 on the DN3c form.
48. Bubble “**A1**”. (See Figure 14 below)

Figure 14– “SOAPT” Section (Page 1, Lower Left, DN3c Form)

S	O	A	P	T	

STEP 2: Scanning the Daily Note Form (DN3c)

Provided that you entered Bob Jones into the patient database in the first tutorial, you are ready to scan the daily note form that was filled out in Step 1 of this tutorial.

NOTE: Once you click the “**Scan Forms**” icon on the “**Main Menu**”, the “**Forms Scanned**” screen will appear. To generate your daily note report automatically each time a DN form is scanned; select “**Generate Daily Note after Scanning Each DN Form**” in the lower left corner of this screen.

IF the “Generate Daily Note After Scanning.....” box is selected follow the steps listed below.

1. The “**Pick Insurance Company**” screen will appear.
2. **SELECT** the Primary or Secondary Insurance Company or click “**NONE**”.
3. Your **DAILY NOTE REPORT** will be generated automatically.
4. Close the report.
5. The “**Forms Scanned**” (Exit Screen) will appear.
6. Select “**EXIT**” or “**MAIN MENU**” to return to the main menu.

You may select whether you want to enter queries after you scan the form or when you generate the document. Additional options available in the setup screens for daily notes are outlined on [Pages 72-78](#) of this manual.

NOTE: The default query option is set to “**Scan**” (enter queries after scanning). To change the default to “**Document**” (enter queries when generating documents) complete the following steps.

1. From the “**Main Menu**”, select “**Setup**”.
2. Click the “**Daily Notes 1**” tab at the top of the screen.
3. Locate the “**DN-3 Query**” heading and choose “**Document**”.

1. Scan the “**DN3c**” form according to the guidelines on Page 23.
2. If you have set your default query option to “**Scan**”, enter the queries according to the guidelines on page [32-33](#). If you have set your default query option to “**Document**”, skip this step and continue with #3 below.
3. Press “**Enter**” on your keyboard or click “**Documents**” when scanning has completed.

STEP 3: Generating the Daily Note Report (DN3c)

The process of generating the Daily Note report is similar to generating reports in Tutorial 1.

1. Notice that you are in the **“Generate Documents”** screen for Bob Jones. Select **“Daily Notes”** under **“Reports”** and click **“Generate”**.

You are now in the “Daily Notes, Select Visits” screen. (See Figure15 below) The lower portion of this screen contains a number of different options. These options are outlined below.

“Medicare” – When selected, the patient’s **date of birth** and **Medicare number (HIC#)** will appear at the top of the report, the doctor’s signature will appear at the bottom, and **“1/Pg”** will automatically be selected.

“Cover Letter” - When selected, a cover letter addressed to the patient’s insurance company will precede your daily note report.

“1/Pg” - If selected when generating multiple daily note reports, each daily note report will begin on a separate page.

“Sign Note” – Daily Note signature options are outlined below.

“None” – No signature will appear at the end of your daily note report.

“Attended” – This option is used when there is more than one doctor in the same office. If selected, the signature of the attending doctor (doctor number bubbled on the form) will appear at the end of the daily note report.

“Signed By” – When selected, the signature that appears in the **“Signed By”** field (Lower right corner, Figure 15) will override the doctor number bubbled on the form and appear at the end of the daily note report.

“Signed By & Footer” – The signature appearing in this area (Lower left corner, Figure15) is the signature that will appear under the signature line at the end of your daily note reports and in the footer at the bottom of the page.

Figure 15– Generate Documents – “Daily Notes, Select Visits” screen

2. If you have set your default query option to “**Document**”, you will be prompted to enter the queries now. Refer to “**Completing the Query Screens**” on pages [32-33](#) for help.
3. Once the queries have been entered, your daily note report will be generated automatically.

Figure 16– Generated Daily Note Report - SAMPLE

Re: Mr. Bob Jones
Daily Progress and Procedural Notes

January 15, 2012 - Attending Physician: Doctor Your, D.C.

SUBJECTIVE

Mr. Jones complains at his appointment today that his principal complaints are as follows: The patient is aggravated by a severe grade of sharp, shooting pain with stiffness and soreness which occurs frequently in his neck on the right side. In his neck on the left side he has a severe degree of shooting pain with stiffness and soreness that occurs frequently. The patient notes that the pain with stiffness and soreness remains unchanged in both sides of his neck. On a visual analog scale of 0 to 10 with 0 being no pain and 10 being the worst pain possible, he reports his overall pain is an 8. The patient states that his symptoms are worse in the morning and when standing for prolonged periods of time. The patient was instructed to fill out the Pain Diagrams indicating each body area they experience pain. He was also shown how to place a number that specifies the level of pain and percentage of the day that pain occurs. He relates that he has not had any new provocative incident. The patient also reports pain that radiates from the neck to the fingers on the right side.



OBJECTIVE

My leg length measurement confirms the right leg to be 1/8 of an inch short due to postural compromise. An evaluation of the cervical spine reveals the existence of subluxation coupled with myospasm located in the left upper range. There are signs of joint dysfunction with accompanying spastic, inflamed, and tender musculatures specific to the right upper cervical region which radiates. Evidence of malposition is identified plus spastic deep paraspinal musculatures localized to the left middle cervical spine. Joint dysfunction is evident together with myospasm, inflammation, and tenderness overlying the right middle cervical range. Malalignment is apparent together with muscular spasm of the left lower cervical range. Subluxation is present together with spastic, inflamed, and tender deep paraspinal musculatures in the right lower cervical range which radiates. Assessment of the patient's posture confirms a right lateral flexion of the head to the thorax. He stood with anterior translation in the cervical spine. Cervical ranges-of-motion are decreased with severe pain, conforming with clinical evaluation.

ASSESSMENT

There is no change in the preliminary assessment.

PLAN

His appointment frequency is determined to be three sessions per week for twelve visits. His home care recommendations are changed to rest and ice. This session a multivitamin was prescribed.

Doctor Your, D.C.
123 E Federal Hwy, Suite 1a, Pompano Beach, FL 33062

Pg -1

Procedural Notes

TREATMENT

Therapy, as called for by the examination outcomes, are given to Mr. Bob Jones. Cervical range-of-motion and resolve segmental dysfunction a light metered force manual adjustment are applied. A light metered force adjustment is utilized on C3, and C7. A manual adjustment is used on C5 and C6. A light metered force is delivered to the right wrist. The following modalities are administered to the right wrist for fifteen minutes. Cryotherapy is employed to reduce local tissue swelling. To decrease pain and increase range of motion, Myofascial release is performed. In accordance with the cervical therapeutic exercise protocol outlined in the manual, utilized for the purpose of improving strength and restoring functional cervical spine and supporting structures, therapeutic strengthening and stabilization exercises are explained to and performed by the patient for fifteen minutes. Bob Jones completed the protocol well.

Doctor Your, D.C.
123 E Federal Hwy, Suite 1a, Pompano Beach, FL 33062

Pg -2

Summary – Patient Visit #1

In this part of the “**Daily Note/Travel Card**” tutorial you should have completed the following three steps. Next, you will print a “**Travel Card**” for Bob Jones’ second visit.

STEP 1

**Complete the
blank Daily
Note form**

STEP 2

**Scan the Daily
Note form**

STEP 3

**Generate the
Daily Note
Report. (As
needed)**

Before Printing the Travel Card

For training purposes, some of the bubbles you marked on the form in the first part of this tutorial will need to be customized before you print the travel card for Bob Jones' second visit.

The first item we will predefine is the **“Other 3”** bubble under **“Today’s Treatment, Modalities”**.

1. From the main menu select **“Utilities”**, then **“Modify Predefines”**.
2. Select **“Daily Notes”** and double click **“DN3c”**. An image of the **“DN3c”** form will appear.
3. Use the left/right arrows at the top of the screen to view the opposite side of the screen image.
4. Locate **“Today’s Treatment, Modalities”**. (Page 2, lower left corner)
5. Locate the **“Other 3”** bubble within this section.
6. Click the green bubble at the very top of the **“Other 3”** column.
7. A smaller **“Modify Predefs”** screen will appear. Each modality is entered into two category divisions. They are **“Description”** and **“Expected Results”**. The **“Location”** box at the top of this screen should read **“DN#3: TODAY’S TX-Modalities Other 3[H1B16[30]] - Description”**
8. Click **“Add”**.
9. Type **“electrical muscle stimulation”** into the **“Text ID”** box.
10. In the **“Travel Card Id”** box, type **“EMS”**.
11. Check the **“Always Use”** box and click **“Save”**.
12. The **“Location”** box at the top of your **“Modify Predefs”** screen should now read **“DN#3: TODAY’S TX-Modalities Other 3[H1B16[15]] - Expected Results”**
13. In the **“Text ID”** box, type **“EMS”**
14. In the **“Predefined Text”** box, type **“to reduce pain and inflammation”**.
15. Check **“Always Use”** and click **“Save”**.

The next bubble we will predefine is for the **“Cervical”** column in the **“Rehab Therapy”** section.

16. Locate the **“Rehab Therapy”** section on the screen image of the **“DN3c”** form. (Page 2, bottom center)

17. Locate the **“Cervical”** column within this section.
18. Click on the green bubble at the bottom of the **“Cervical”** column.
19. The smaller **“Modify Predefs”** screen will appear. The **“Location”** box should read ***“DN#3: TODAY’S TX-Rehab Therapy [H2B1[30]] – Cervical”***.
20. Click **“Add”**.
21. In the **“Text ID”** box, type **“PNF Stretches – SCM”**.
22. In the **“Travel Card Id”** box, type **“PNF-SCM”**.
23. In the **“Predefined Text”** box, type **“PNF stretching was performed bilaterally on the SCM muscles”**.
24. Click **“Save”**.

The next bubble we will predefine is the **“1”** bubble in the **“Man/Adj.”** section.

25. Locate the **“Man/Adj.”** section on the screen image of the **“DN3c”** form. (Page 2, bottom right)
26. Locate and click on the **“1”** bubble within this section.
27. The smaller **“Modify Predefs”** screen will appear. The **“Location”** box should read ***“DN#3: Man/Adj-Misc[H3D[01]] - Other 1”***
28. Click **“Add”**.
29. In the **“Text ID”** box, type **“multivitamins”**.
30. Click **“Save”**.

The last bubble we will predefine before printing the travel card is the **“A1”** bubble.

31. Locate and click on the **“A1”** bubble on the screen image of the **“DN3c”** form. (Page 1, lower left corner)
32. The smaller **“Modify Predefs”** screen will appear. The **“Location”** box should read ***“DN#3: Of Additional Note 1[F4[1]] – Assessment”***
33. Click **“Add”**.
34. In the **“Text ID”** box, type **“Range of Motion – Cervical”**
35. In the **“Predefined Text”** box, type **“Tests indicate an increase of 5% in cervical range of motion since initial evaluation.”**

36. Click “Save”, then click “Exit” at the top of the screen.

STEP 4: Printing Travel Cards

The Travel Card is a feature that allows doctor and staff to view specific information about a patient’s previous visit(s) and can be printed prior to the patient’s next visit.

Information printed on the Travel Card includes:

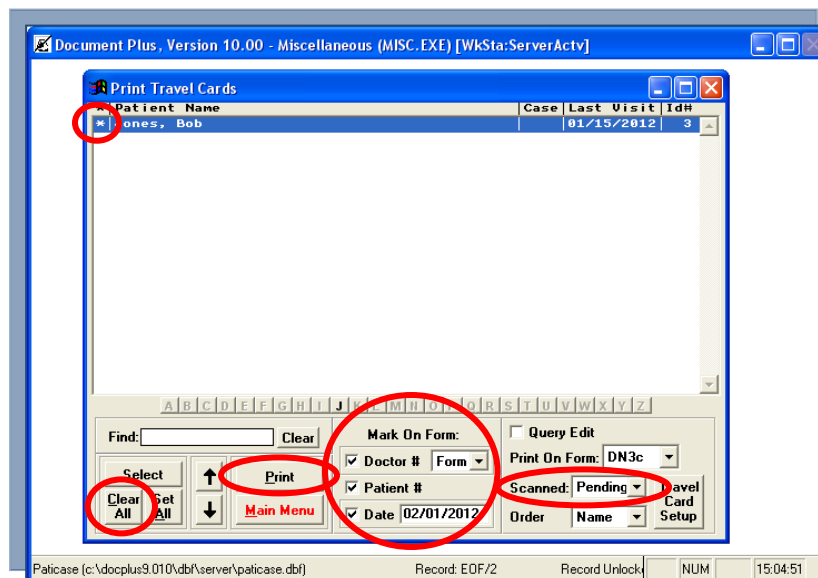
- Diagnosis and X-Ray information from the initial visit or re-evaluation
- Symptom and treatment information from the previous visit
- Re-evaluation and X-Ray retake dates
- Visit and plan information
- “Notes” section for in-office communication

1. From the Main Menu, click on “Travel Card”. The “Print Travel Card” screen will appear (shown in Figure 17 below).

Some important features in the “Print Travel Cards” screen are outlined in red in Figure 17 and explained below.

- The **asterisk** to the left of the patient name indicates that this patient is selected and a travel card will print for him/her.
- “Clear All” – By default ALL patients in the list are selected. This feature allows the option of clearing all of the selected patients.
- “Mark on Form” – This section allows the option of pre-printing the doctor number, patient number, and date (or any combination of the three) onto the travel card.
- “Scanned” – This feature allows you to choose the way patients appear in the “Print Travel Cards” screen. Options are “All” (all patients), “New” (new patients), and “Pending” (patients that have forms scanned but have not yet had a travel card printed for the most recent visit.)

Figure 17– “Print Travel Cards” screen



2. You should see an asterisk to the left of Bob Jones' name. This means he is selected to have a travel card printed.
3. Load a BLANK daily note form (DN3c) into your printer as if the upper left corner of Pg. 1 were the logo on a sheet of letterhead.
4. Click **"Print"**. The next screen will give you the appropriate number of daily note forms to load. In this case it should specify **"1"** form.
5. Click **"Print"** again.
6. Remove the travel card from the printer. You should see information printed in the upper left corner of Pg. 1.
7. Check the alignment of the doctor and patient numbers. The **"1"** should be bubbled under **"DR#"** and the **"3"** should be bubbled under **"Patient Number"**. If the pre-printed black squares do not line up, you will need to adjust the calibration settings before going any further. Please contact our technical support department at 800-642-0600 for assistance.

NOTES:

- a. By default, ALL patients in the current list are selected (as indicated by an asterisk to the left of the patient name). This means the daily note is active and a travel card will print.
- b. Patients can be selected or de-selected by **double clicking** on the name or by **highlighting the name and clicking "select"** at the bottom of the screen.
- c. To save time, consider printing all travel cards for the day either first thing in the morning, or the day before.

Customizing "Travel Card Setup"

You may want to change the default settings for the way your **"Print Travel Cards"** screen appears.

1. Click on **"Travel Card Setup"** in the lower right corner of the **"Print Travel Cards"** screen.

The **"Travel Card Default"** screen will appear (Figure 18 below)

Figure 18– "Print Travel Cards" screen

The screenshot shows the 'Travel Card Default...' dialog box with the following sections and callouts:

- Options:**
 - ☒ Mark Doctor Number
 - ☒ Mark Patient Number
 - ☐ Mark Date
 - ☒ Set Pending Automatically
 - ☒ New Patients
- Defaults:**
 - Form-Id-Version-RevLtr: **DN3c** (dropdown menu)
 - Scanned: **Pending** (dropdown menu)
 - Order By: **Name** (dropdown menu)
- Printer:** (text field)
- Buttons:** Save, Cancel

Callout boxes provide additional context:

- Change defaults for items that will pre-print onto the form and for the way your patient list is sorted in the **"Print Travel Cards"** screen. (Points to the Options and Defaults sections)
- Change defaults for the way your patient list is sorted in the **"Print Travel Cards"** screen. (Points to the Order By dropdown)
- Select a default printer for printing travel cards. (Points to the Printer text field)

Understanding the Travel Card – Part I

The information from your initial evaluation and previous treatment is printed onto a blank daily note form (DN3c). The form then becomes your “**Daily Note/Travel Card**” and will be used for documenting symptoms, findings, and treatment for the current visit. The information found on the travel card is outlined below.

Figure 19– “Travel Card” (Upper left corner, Pg. 1)

Ce-Dx: (P)721.1 Cerv Neuro Vas Comp, (P)723.1 Cervalg, (P)723.4 Cerv Radi, (P)724.2 Lumbg, (P)724.4 Lum Neuritis/Radi, (P)729.1 Lum Myalg/Myositi, (P)847.0 Cerv Dn-Sbj: BiNk=P+Sf+Sr, i>S, c>Sp+St, f>F, s>U! Xray: Cerv: NDS=Mo@C4-C5. Wdg=Ant@C4-C5. Lst=Ant@C4. Istb=w/flx+ext@C5. SpnLam@C4. Cv=St. PP=Bi@C1. Note: rt. hip repl. P=CP=30!	Plan	2 / 12 (2)	Schd	3/wk
	n/RE	03/24/08	XR	03/24/08
	Adj: Mm: C5, C6!			
	Thrp: Ice(15): UML-Cerv; EMS(10): UML-Cerv; PNF-SCM(10)!			
	Tx Resp: VAS= 8!			
	Hby:			

Beginning in the upper left corner:

Ce-Dx: (Clinical Evaluation – Diagnoses) - This section contains the diagnosis information from the patient’s initial clinical evaluation. Once a re-evaluation is done, the heading becomes “**Re-Dx**”, and reflects the updated diagnoses. (If “**New Additional**” is bubbled on the “**DN3c**” form the new diagnosis codes will replace the old. When a re-evaluation is done, the new codes take precedence and replace the previous codes from the “**DN3c**” form.)

Dn-Sbj: - (Daily Note – Subjective) – This section reflects the information bubbled in the “**Symptoms**” section on the previous daily note (DN3c form).

[BiNk = P+Sf+Sr] – Bilateral Neck = Pain, Stiffness, Soreness. *Indicates location and description of the problem (1st column, “Symptoms, Section I”).

[i>S] – Intensity = Severe. *Indicates severity of the problem (2nd column, “Symptoms, Section I”).

[c>Sp+St] – Characteristics = Sharp, Shooting. *Indicates characteristics of the problem. (3rd column, “Symptoms, Section I”).

[f>F] – Frequency = Frequent. *Indicates the frequency of the problem. (4th column, “Symptoms, Section I”).

[s>U] – Status = Unchanged. *Indicates whether the problem is improving or not. (5th column, “Symptoms, Section I”).

X-Ray: - This section contains X-Ray information from the Radiographic form completed during the patient’s initial visit.

Note: - This section contains in-office notes that have been either typed in under the “**Notes**” tab in the patient database or entered via the “**SOAP2**” bubbles in the lower left corner of page 1 on the “**DN3c**” form.

Plan: - The information in this section reflects the current visit number (2), the number of total visits in the current treatment plan (12), and the total number of accumulated visits for the patient up to this point (2). ([See Figure 19, Pg. 63](#))

Schd: - This section reflects the patient’s visit schedule (3/wk) for the current treatment plan.

n/Re: - This section reflects the Re-Evaluation date entered into the “**Information 2**” screen of the patient’s database in the previous step of this tutorial. If no date was entered in the previous step of this tutorial, “**I/CE**” would appear in this section and the date reflected would be the initial examination date.

XR: - This section reflects the X-Ray date entered into the “**Information 2**” screen of the patient’s database in the previous step of this tutorial.

Adj: - The information in this section reflects the adjustments bubbled under “**Today’s Treatment, General Listings**” on the previous visit.

Thrpy: - This section reflects the therapies documented in “**Today’s Treatment, Modalities**” and in “**Rehab Therapy**” on the previous visit.

Tx Resp: - This section reflects information documented in the “**Progress**” and “**Response to Tx in %**” areas on the previous visit.

Additional information about the previous visit(s) appears in its respective section on page 1 of the “**DN3c**” form.

“**Objective**” section: ([See Figure 20, Pg. 65](#))

- To the right of “**Leg Length Deficiency**” you should see “**R1/8**”.
- In “**Biomechanical Exam**”, under “**left**” and “**right**”, you should see the abbreviations for the items bubbled on the previous “**DN3c**” form. (Left = “**XS**”, Right = “**XSTIR**”)
- In “**Posture**” you should see an “**R**” to the left of “**Head Tilt**”.
- In “**Forward Flexion**” you should see a “**C**” to the right of “**Cervical**”.
- In “**Range of Motion**” you should see “**D+++**” to the right of “**Cervical**”.

“**Today’s TX, General Listings**”: ([See Figure 20, Pg. 65](#))

- To the right of “**Wrist**” (in the upper extremity column) you should see an “**R**” and you should see “**INST**” above that.

“**Thrust Report**”:

- To the right of the three column “**Thrust Report**” you should see a “**1**” beside each section marked for the last visit followed by the specific listings for that area. ([See Figure 21, Pg. 65](#))

Figure 20– “Travel Card” - “Objective” and “Today’s Tx, General Listings” sections (Pg. 1, Left)

OBJECTIVE ☐ Same Assessment ☐ Equal

Leg Length Deficiency ☐ Left ☐ Right

Biomechanical Exam

LEFT: sublux, spasm, tender, infirm, radiate, R 1/4

RIGHT: sublux, spasm, tender, infirm, radiate, XSTIR, XSTIR, XSTIR

Posture: R, L, R

Forward Flexion: Cervical c, Lumbar, Pain

Range Of Motion: Cervical, Dorsolumbar, D++

TODAY'S TX-General Listings

Tx1: Inst, MM, FixD, 1, 2, 3

C: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

T: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

L: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

Tx2: Inst, MM, FixD, 1, 2, 3

C: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

T: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

L: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

Inst, MM, 1, 2, 3

AC Joint, Clavicle, Elbow, Wrist, Hand, Thumb

Inst, MM, 1, 2, 3

Foot, Patella, Coccyx, Psoas

Patient Tolerated Procedure Well

Figure 21 – “Travel Card, Thrust Report” (Pg. 1, Right)

TMJ

Occiput: Inst, 1 Rp

Atlas: 1 A

C2: 1 R

C3: 1 Rs

C4

C5

C6

C7: 1 A

Humerus

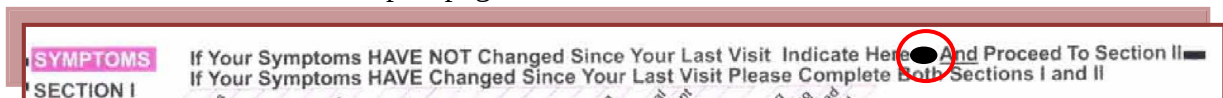
Scapula

NOTE: The “1” represents “One visit ago” NOT “Visit number one”. Each time a travel card is printed listings from the previous visit will appear. The travel card will reflect up to five visits with “1” always representing the most recent visit.

STEP 5: Filling out the Daily Note Form (DN3c) – SECOND VISIT

We will now use the form with the printed travel card information for Bob Jones' second visit. The purpose of this part of the tutorial is so that you can gain an understanding of when and how the “Same As” bubbles are used.

1. Bubble yesterday's date in the date columns in the upper right corner on page 1.
2. The “1” should be bubbled under “DR#” and the “3” should be bubbled under “Patient Number”. If the pre-printed black squares do not line up, you will need to adjust the calibration settings before going any further. Please contact our technical support department at 800-642-0600 for assistance.
3. Turn the form to page 2 and begin with the “Symptoms” section.
4. Fill in the bubble next to: “If your symptoms have not changed since your last visit, indicate here....” at the top of page 2.



Even though the patient fills in the bubble stating that symptoms have not changed since their last visit you can still make some changes in “Symptoms, Section I”.

5. On the “RIGHT SIDE”, “Neck” area:
 - a. In the second column, bubble “Moderate”.
 - b. In the last column, bubble “Improving”.
6. On the “LEFT SIDE”, “Neck” area:
 - a. In the second column, bubble “Moderate”.
 - b. In the last column, bubble “Improving”.
7. Go to “Symptoms, Section II”.
 - a. In the “Pain Scale”, bubble “7”.
 - b. “If your symptoms change, when are they worse?”, mark “Morning”.
 - c. Fill in the “Pain Diagrams” similar to the way they were filled in on the last visit. This time, document a decrease in pain intensity.
8. Bubble “No New Aggravation/Injury”.
9. You would now have the patient sign and date the form in the “Patient Signature” and “Date” areas. Go ahead and do this for Bob Jones.
10. In the “Assessment” section, bubble “Prevs. Unchanged”.
11. In “Progress”, bubble “Improving”.
12. In “Response to Tx. In %”, bubble “10” under “Reduced Spasm”, “Reduced Tenderness”, and “Reduced Inflammation”. Bubble “20” under “Increased Mobility” and “Increased Activities of Daily Living”.

13. Under **“Today’s Treatment, Modalities”**, bubble **“Same Tx”**.

NOTE: When you bubble **“Same Tx.”** in **“Today’s Treatment, Modalities”** you can make NO changes in this section. If a modality was added or omitted from the day’s treatment you would NOT bubble **“Same Tx”** and would simply fill in the entire section again.

14. In the **“Plan”** section, bubble **“Per Initial/Prev. Plan”** since nothing has changed since we completed the visit schedule on the last visit.

15. In **“Rehab Therapy”**, bubble **“Same Tx”**.

16. Turn the form to Page 1 and locate the **“Objective”** section.

17. In the **“Objective”** section, bubble **“Same Assessment”**.

NOTE: When **“Same Assessment”** is bubbled in the **“Objective”** section, changes can only be made in **“Leg Length Deficiency”** and **“Range of Motion”**. If you need to mark changes in an area other than the previous two, you would NOT mark **“Same Assessment”** and would simply fill out the entire section again.

18. In **“Leg Length Deficiency”**, bubble **“R1/4”**.

19. In **“Range of Motion”**, **“Cervical”** area, bubble **“Decreased”** and **“Moderate”**.

20. In the **“Thrust Report”** section, locate and bubble **“SAT Except”** at the top of the center column.

21. In the column on the far right locate **“Occiput”** and bubble the **“N”**. (**“neutral”** or **“needs no adjustment this visit”**)

22. In **“C2”**, bubble **“R”** (right)

23. In **“C4”**, bubble **“INF”** (inferior)

NOTES: a. We took **“Occiput”** off our list by bubbling **“N”**, added **“C4”** and changed **“C2”**.

- b. When **“SAT Except”** is bubbled, changes can only be made to the **“Thrust Report”**. NO changes can be made on the left side of the form under **“Today’s TX – General Listings”**. If you need to make changes to **“Today’s TX – General Listings”** you would NOT bubble **“SAT Except”** and would simply mark ALL adjustments for that day.

24. Mark **“Y”** for **“Patient Tolerated Procedure Well”**.

25. Scan the form and generate the daily note report according to the guidelines on pages [56-57](#).

26. You have completed the **“DN3c”** daily note form for Bob Jones’ second visit. To print a travel card for Bob’s third visit, follow the instructions under **“[Step 4: Printing Travel Cards](#)”** on [pages 61-62](#). Once the second travel card has printed, continue the tutorial on [Page 68](#).

Understanding the Travel Card – Part II

“Understanding the travel card” is covered in detail on [Pages 63-65](#) of this manual. However, there are items we marked on the second visit and did not mark on the first. How these items appear on the travel card are outlined below.

Figure 22 – “Travel Card” (Upper left corner, Pg. 1) – “Tx Resp” Section

Plan	3 / 12 (3)	Schd	3/wk
n/RE	05/10/08	XR	05/10/08
Adj: Mm: C5, C6!			
Thrpy: Ice(15): UML-Cerv; EMS(10): UML-Cerv; PNF-SCM(10)!			
Tx Resp: Prog=I, VAS= 7, S=10, T=10, I=10, M=20, A=20!			
Hby:			

In the “**Tx Resp**” section of the travel card (shown above in Figure 22) you will now see abbreviations for the items marked in the “**Progress**” and “**Response to Tx in %**” areas of the DN3c form on the previous visit.

[**Prog = I**] – Progress = Improving

[**VAS = 7**] – Visual Analog Score (from the pain scale) = 7

[**S = 10**] – Reduced Spasm, 10%

[**T = 10**] – Reduced Tenderness, 10%

[**I = 10**] – Reduced Inflammation, 10%

[**M = 20**] – Increased Mobility, 20%

[**A = 20**] – Increased Activities of Daily Living, 20%

You will also notice that on the far right side of the form, in the “**Thrust Report**” section, you now have columns “**1**” (One visit ago) and “**2**” (Two visits ago). *Remember that the travel card will print listings from up to five visits. The items listed under “**1**” ALWAYS reference the most recent visit. The dates of those visits appear on page 1 of the DN3c form in the upper right corner above “**Patient Name**”. ([See Figure 23, Pg. 69](#))

Figure 23 – “Travel Card” – “Thrust Report”

TMJ	
1	2
3	4
5	6
7	8
9	10
11	12
13	14
15	16
17	18
19	20
21	22
23	24
25	26
27	28
29	30
31	32
33	34
35	36
37	38
39	40
41	42
43	44
45	46
47	48
49	50
51	52
53	54
55	56
57	58
59	60
61	62
63	64
65	66
67	68
69	70
71	72
73	74
75	76
77	78
79	80
81	82
83	84
85	86
87	88
89	90
91	92
93	94
95	96
97	98
99	100

STEP 6: Filling out the Daily Note Form (DN3c) – THIRD VISIT

We will now use the form with the printed travel card information for Bob Jones' third visit. The purpose of this part of the tutorial is so that you can gain an understanding of how to document a new injury and add additional diagnoses to the daily note form (DN3c).

1. Bubble today's date in the date columns in the upper right corner on Page 1.
 2. The **"1"** should be bubbled under **"DR#"** and the **"3"** should be bubbled under **"Patient Number"**. If the pre-printed black squares do not line up, you will need to adjust the calibration settings before going any further. Please contact our technical support department at 800-642-0600 for assistance.
 3. Turn the form to Page 2 and begin with the **"Symptoms"** section.
 4. **Fill in the bubble next to: "If your symptoms have not changed since your last visit, indicate here...."** at the top of Page 2.
 5. On the **"RIGHT SIDE"**, **"Low Back"** area:
 - a. In the first column, bubble **"Pain"**, **"Stiffness"**, and **"Soreness"**.
 6. In **"Symptoms, Section II"**:
 - a. Bubble **"8"** in the pain scale.
 - b. **"If your symptoms change, when are they worse?"**, mark **"Morning"**.
 - c. Fill in the **"Pain Diagrams"** similar to the way they were filled in on the last visit. This time, document a decrease in pain intensity.
 - d. Bubble **"New Injury"** and write **"pulled low back"** on the form in the space provided
 7. In the **"Assessment, Diagnosis"** section:
 - a. Bubble **"Prevs. Unchanged"** and **"New Additional"**.
- NOTE:** When **"Prevs. Unchanged"** and **"New Additional"** are both bubbled, the **"New Additional"** diagnoses are added in front of the old diagnoses on the travel card. When only **"New Additional"** is bubbled, the old diagnosis codes are removed and only the new code(s) will appear on the travel card. The information will also appear in your daily note report.
8. For **"Progress"**:
 - a. Bubble **"Worsening"**.
 9. In the **"Plan"** section:
 - a. Bubble **"Per Initial/Prev. Plan"**.
 10. In the **"Today's Treatment, Modalities"** section:
 - a. Bubble **"Same Tx"**.

11. For **“Rehab Therapy”**:
 - a. Bubble **“Same Tx”**.
12. Turn the form to Page 1 and locate the **“Objective”** section.
13. In the **“Objective”** section:
 - a. Bubble **“Same Assessment”**.
14. In the **“Thrust Report”** (Page 1, Right):
 - a. Bubble **“SAT Except”** at the top of the center column.
15. Bubble **“Y”** for the statement **“Patient Tolerated Procedure Well”**.
16. Scan the DN3c form, enter the queries, and generate the daily note report according to the instructions on [Pages 55-57](#).

NOTE: When entering the **“New Additional”** diagnosis query, you may choose the codes from a predefined pick list.

You have completed the “Basic” and “Daily Note/Travel Card” tutorials! If you have questions or need further assistance please contact the Document Plus Training Department at (800) 642-0600.

Section D - “Advanced Setup” - Setting Your Preferences

Overview

The Document Plus system offers many customization options for daily note reports, narratives, and screen defaults. A number of those can be selected in the “Setup” portion of the software. This section outlines the options under each setup tab.

Figure 1- Set-Up: “Daily Notes 1” Tab

Document Plus, Version 10.00 - Miscellaneous (MISC.EXE) [WkSta:ServerActv]

Setup Information

Settings | **Daily Notes 1** | Daily Notes 2 | Consult Notes | Miscellaneous 1 | Miscellaneous 2

Daily Notes:

Format: Report By: Report Dates:

DN-3 Query: ☐ Document ☒ Scan ☒ Subluxation From Thrust Segment Grp:

Heading: ☒ Symptoms Status Unchanged

Adjustment Reason: ☐ Subluxation DN#3 Complaints(Order): ☐ From HQ#2

Report: ☒ Visits This Plan Adjustments: ☒ Segments ☐ Ranges

Travel Card: Complaints From: ☒ Current (DN) ☐ Initial (HQ) Include: ☒ CoPay

SOAP2: ☐ Note ☒ Travel Card Default Treatment Billing:

Batch: ☒ All Patients In One Document ☐ Separate Document For Each Patient

Layout: ☐ Cover Letter ☒ One Per Page Sign Note: ☐ None ☐ Attended ☒ Signed By

Region: Adjustment #: Adjustment Text:

Document | **Actions**

Layout - Letter | Layout - Report | Save | Cancel

Pmsware [c:\docplus9.010\db\p\pmsware.dbf] Record: EOF/11 Record Unlock NUM 15:24:04

Complete the following steps to customize the “Daily Notes 1” screen:

1. **Format:** You may choose “Paragraph” or “SOAP”.
2. **Report By:** Select an option for batch printing of Daily Notes. The report will be printed in order of patient “Name” or patient “Number”.
3. **Report Dates:** Lists daily report dates in either “Ascending” (last visit date on top) or “Descending”.
4. **DN-3 Query:** If “Document” is selected, query screens will appear when generating a report. If “Scan” is selected, query screens will appear while scanning forms.
5. **Subluxation from Thrust:** If this is selected the number of regions bubbled in the “thrust report” section on the daily note form will be compared to the objective section and will state subluxation in those areas whether you have marked “subluxation” on the form or not.
6. **Segment Grp:** This determines how consecutive segments will be presented in your reports. Using the default setting of “5” as an example; if segments “C1, C2, C3, C4, C5, C6, and C7” are bubbled on the daily note form, your report will read: “segments C1, C2, and C3 through C7”. Notice that the last 5 segments were grouped together instead of being listed individually and separated with commas.

7. **Heading: “Attending Clinician”** - This heading is what shows up in reports when “**Attended**” is checked (either in this screen or in the “**Daily Notes, Select Visits**” screen). You might consider changing this to “**Attending Provider**” if you have physical therapists and/or other practitioners that will be sending out daily notes.
8. **Symptoms Status Unchanged:** If selected, the text in your daily note will appear as “**unchanged**” when using the “**same as**” bubble (i.e. If you bubble “**worsening**”, and on subsequent visits bubble “**symptoms not changed**”, the text will use the word “**unchanged**”, instead of “**worsening**” repetitiously.)
9. **Adjustment Reason:** If “**Subluxation**” is selected, “**to correct a subluxation**” will be added to the “**Treatment**” section of your daily note report.
10. **DN#3 Complaints:** If “**HQ2**” is selected; the listing of subjective complaints will be ordered from “**HQ2**” and listed as primary and secondary. If unselected, it will list everything as primary on daily notes. It is our recommendation that you leave this unselected.
11. **Report: “Visits This Plan”** - If you select this, the information you bubble in the “**Visits This Plan**” area of the daily note form will appear in your daily note report. If unselected, the information will only appear on the travel card.
12. **Adjustments:** If “**Segments**” is selected, adjustments documented on the daily note form (DN3, Pg. 1, “**Today’s TX**” section) will appear in the treatment section of your daily note report as specific segments. (**Example:** A manual osseous adjustment is applied to C5 and C6.) If “**Ranges**” is selected the information will appear in general terms. (**Example:** A manual osseous adjustment is administered to the lower cervical spine.)
13. **Travel Card Complaints:** For the travel card complaints section, you may choose whether the symptom information is pulled from the current daily note (DN) form or the initial Health Questionnaire (HQ). Default is current daily note (DN).
14. **Include CoPay:** If selected, the CoPay information you have put in the “**Insurance 1**” screen in the patient database will print on the daily note travel card in the “**Notes**” section.
15. **SOAPT2:** You may choose to record additional information by using the “**SOAPT2**” bubbles on the daily note form (DN3c). By default, “**Travel Card**” is selected. This means that information entered using the “**SOAPT2**” bubbles should be short and abbreviated and will appear ONLY on the travel card. If “**Note**” is chosen, the bubbles will function similar to the “**SOAPT1**” bubbles and appear ONLY in the daily note report.
16. **Default Treatment Billing:** If you are using the DN3 or DN4 forms, you may select a default attended/unattended time for modalities without actually marking it on the form.
17. **Batch:** When generating daily notes by batch you can select all patients to print out in one document or print a separate document for each patient. What you select here will be your default settings.
18. **Layout:** If “**Cover Letter**” is selected, a cover letter will appear each time daily notes are generated. If “**One Per Page**” is selected, each daily note will begin on a new page.
19. **Sign Note:** If “**None**” is selected, no default signature will appear. Select “**Attended**” and the signature of the doctor bubbled on the form will be added to the daily note. If “**Signed By**” is selected, you will be able to select the signature from a list of doctors. By selecting the information here you will not have to

select them in the “**Daily Notes Select Visits**” screen. This will be for all patients. Default is “**None**” so you can choose different formats for different patients.

19. Region, Adjustment #, and Adjustment Text: This allows you to customize adjustment types on the four visit daily note form (DN2).

20. After completing the steps above, click on the “**Daily Notes 2**” tab (See Fig. 2 below) to continue the set-up process.

Figure 2 - Set up: “Daily Notes 2” screen:

Complete the following steps to customize the “Daily Notes 2” screen:

- Section Not Marked Warnings:** If you mark something in a particular area of the form on a previous visit and did not mark the same area on the next visit, selecting these will give you an error. By default, all are selected.
- Section Marked Warning days:** Allows you to choose how many days you want to go back on a previous daily note before it will NOT give you an error for sections not marked.
- 9894x Missing Warning.** If this is selected you will get an error if you have something marked in the objective section and did not bubble in one of the 9894x codes on the other side of the form. If you have Subluxation from Thrust selected in the setup screen and you marked something on the thrust areas of the form you will also get this error if nothing is marked in 9894x codes.
- Affects Condition:** “**Visits**” and “**Days**” fields will pull query information from the HQ2 or HQ3 form (section B, numbers 5 and 6) regarding what affects their condition. If there is a “**3**” in the “**Days**” field you will be prompted every three days to select what affects the patient’s condition. The text will be added to the “**Subjective**” section of the daily note report after the pain scale information.

5. **CBP Traction Weight (C2W & CLT):** When this box is selected and a DN4 form is scanned, a query appears to allow you to insert traction weight. This will appear in your daily note report.
6. **Re-Scan Query Edit:** If selected, queries will appear every time you scan/re-scan a daily note form (even when “Always Use” is selected for a particular item)
7. **New Injury Warning HICFA Box 14:** Selecting this box will trigger a validation warning if “New Injury” is bubbled on a DN form upon scanning. This is a reminder for you to update BOX 14 on the HICFA form.
8. **Pain Diagram Instructions:** If selected, the following sentence will appear in the “Subjective” section of your daily note reports: *“The patient was instructed to fill out the Pain Diagrams indicating each body area they experience pain. He was also shown how to place a number that specifies the level of pain and percentage of the day that pain occurs.”* The “Effective” date appears when the “Pain Diagram Instructions” option is first selected. The above sentence will not automatically appear in daily note reports from forms scanned prior to the date shown.

Figure 3 - Set-up: “Consult Notes” screen:

Complete the following steps to customize the “Consult Notes” screen:

1. **CE#0/2-** (Race, Demeanor, Posture, Head, Eyes, and Thorax) – When using the Clinical Evaluation #2 (CE2) form this will allow you to include your findings on the selected variables in your daily note report. If you do not want to be queried for these in your documents, de-select any or all of the options prior to scanning forms.
2. **INS – “History of Accident”:** This will include a “History of Accident” section in all insurance documents. If you de-select this option the “History of Accident” will be precluded. You must do this PRIOR to scanning forms.
3. **Pain Modifiers:** If selected, pain modifiers (mild, moderate and severe) will appear in the reports. If unselected the modifiers do not appear. Default is selected.

4. **OM:** If “**Dates Administered**” is selected, the software will assist you in selecting the treatment dates for the Outcome Measure sections during the document generation process. If you de-select this option you must manually select the dates prior to document generation. It is recommended that you leave this option selected. If “**NP/RO Activities**” is selected, specific activities from the Roland-Morris and the Neck Pain Disability forms will be listed in your reports. De-select this option and a single sentence will summarize your findings.

6. **Signature:** If “**Proofed**” is selected, “*document prepared but not proofed*” will be added to the end of the document. If “**Insurance**” is selected, the doctor’s signature will be added to the last page of the insurance report.

7. **Malposition /Articular:** If selected, the word “**subluxation**” will be included in reports when using the Clinical Evaluation #3 (CE3) form.

8. **Motor Functions All Normal Max:** By default, in the “**Neurological Assessment**” section on the Clinical Evaluation (CE3) form, you are allowed two exceptions if you bubble normal in all positions. This feature allows you to select as many exceptions as you like.

9. **Date of Accident:** This allows you to choose heading abbreviation for date of accident (i.e. “**D/A**”, “**DOA**” or “**Date of Accident**”)

10. **ASHP: Subluxation From:** If “**Query**” is selected, the subluxation part of the ASHP document will generate a query. If “**CE#3 Malposition**” is selected, the subluxation information is imported automatically from the Clinical Evaluation (CE) form, “**Malposition**” section.

Figure 4 Set-up: “Miscellaneous 1” screen:

Complete the following steps to customize the “Miscellaneous 1” screen:

1. **Type of Practice:** If you choose multidiscipline practice, this feature is irreversible. Please call our technical staff for assistance with this section.

2. **Limited Patient Months (12)** - This field represents a value of time, in this case 12 months. If a patient has been entered into your database and has zero scanned forms on file, they are considered a “limited patient”. You can leave the default values or change them. They are indexed when it is time to purge the database. **Inactive Patient Months (24)** - This field also represents a value of time, in this case 24 months. If a patient has completed treatment and no activity is recorded through scanned forms, they are considered “inactive patients”. You can keep the default settings or change it to suit your practice.

3. **Purge Log Days:** After the number of days shown, you cannot recover any records previously deleted. **Back-up Days:** The system will ask you to back-up after 7 days. You must back-up every 14 days.

4. **Install Mode, Work -Station, and Server Path:** This information is pulled automatically from the installation of Document Plus. You cannot change these fields.

5. **Report Empty Form** – If selected, a warning message will appear whenever a blank form has been scanned. The default setting is active.

6. **Warning Beep:** This sets the number of beeps that are heard when errors are displayed. Default is “Continuous”.

7. **Patients Ordered By** – This feature allows you to choose how patients are ordered in the “Pick Patient” screen. If “Name” is selected, patients will be sorted alphabetically by name. If “DP Number” is selected, patients will be sorted by the Document Plus number assigned by your office. “PM Number” will appear if you have an interfaced practice management software. If selected, patients will be sorted according to the number assigned by your interfaced practice management software.

8. **Screen:** This feature determines the size of your screen. If “Normal” is selected, the default settings apply. If “Maximized” is selected, your screen will always appear maximized. If you choose “Custom”, you are able to adjust the height and width settings manually.

9. **System Id:** This section contains Document Plus technical support information.

Figure 5 Set Up: “Miscellaneous 2” screen:

Document Plus, Version 10.00 - Miscellaneous (MISC.EXE) [WkSta:ServerActv]

Setup Information

Settings | Daily Notes 1 | Daily Notes 2 | Consult Notes | Miscellaneous 1 | Miscellaneous 2

Cover Letters: ☒ Policy # ☒ Claim #

Warnings: ☐ HQ Dysfunction HQ#3 Complaints: ☒ Intensity ☒ Frequency ☐ Status

Nutritional: Mode: None Form: None ☐ Export Report

Export Path:

Documents: Header: ☐ DOB Footer: ☒ Practice ☒ Doctor's Name ☒ Address

Signature: Underline: ☐ Attorney ☒ Cover Letter ☒ Summary Summary: ☒ Form ☐ Current

Doctor: Doctor Marked On Form

Document

Layout - Letter Layout - Report

Actions

Save Cancel

Pmsware (c:\docplus9.010\vb\p\pmsware.dbf) Record: E0F/11 Record Unlock NUM 15:34:10

Complete the following steps to customize the “Miscellaneous 2” screen:

1. **Cover Letters:** Options for this feature are “**Policy#**” and/or “**Claim#**”. Items selected here will appear on cover letters for insurance and attorney reports.
2. **Warnings: “HQ Dysfunction”** – If selected the system will not give validation warnings when scanning the health questionnaire form. It does not override validation errors: those must be entered.
3. **HQ#3 Complaints:** If “**Intensity**”, “**Frequency**” or “**Status**” is selected a warning will appear upon scanning if nothing is marked in those areas. Click “**Continue**” to bypass the warning or correct the form and re-scan it. This serves as a reminder in case you accidentally forgot to bubble something in those areas.
4. **Nutritional Mode:** This section works with our Symptom Survey (SS) form. Please call our tech support department at 800-642-0600 for assistance with setting this up.
5. **Documents:**
 - **Header:** If “**DOB**” is selected, the patient’s date of birth will appear in the header of your reports.
 - **Footer:** You may choose any combination of “**Practice Name**”, “**Doctor’s Name**” and/or “**Address**” to appear in the footer of your reports.
6. **Signature:**
 - **Underline:** This feature will insert a signature line at the end of the document(s) selected.
 - **Summary:** If “**Form**” is selected, the doctor’s signature is pulled from the doctor number bubbled on the form. If “**Current**” is selected, the doctor’s signature is pulled from the “**Doctor**” field on this screen.

If you need further assistance with customizing the “Advanced Setup” screens, please contact our training department at 800-642-0600.

APPENDIX A – Customizing the Daily Note (DN3c Form)

There are a number of items on the DN3c form that can be customized to meet the specific needs of your practice. You may choose to **“Always Use”** a specific item when the corresponding bubble is marked or you may create “pick lists” so that when the forms are scanned you have the option of choosing from a number of entries for a particular bubble. This section outlines items that can be predefined according to the area on the form in which they are located. To customize the daily note form (DN3c), please follow the **“Modify Predefines”** instructions below.

“Modify Predefines” (DN3c)

From the Main Menu in Document Plus;

1. Click **“Utilities”**.
2. Select **“Modify Predefines”**.
3. Click on **“Daily Note”**.
4. Double click **“DN#3”**.
5. An image of the **“DN3c”** form should appear on the screen.
6. Items that can be predefined are colored green or turquoise. On your screen, click on the bubble of the item you wish to predefine.
7. A smaller **“Modify Predefs”** screen will appear.
8. Click **“Add”** and enter your text according to the instructions outlined below.

Customizing “Symptoms, Section II” (Page 2, upper right, DN3c Form)

“Other” – **“Other”** is located in **“Section II”** under **“If your symptoms change, when are they worse”**. This bubble is used to indicate other times of day or conditions that aggravate a patient’s symptoms.

To create a pick list for this bubble containing common entries, follow the eight steps above and type entries into the **“Text ID”** box only, clicking **“Add”** between each entry. Click **“Save/Close”** when finished.

Example of text as it appears in the daily note report: *“The patient reports that his symptoms are worse _____.”*

Examples of what you might enter to complete the above statement: *“when bending”, “when lifting”, “during recreational activities”, and “before getting out of bed”.*

“New Injury” – **“New Injury”** is located beneath the Pain Diagrams in **“Section II”**. A patient would use this bubble when a new injury or exacerbation of an old injury has occurred.

To create a pick list for this bubble containing entries for common injuries, follow the eight steps above and type entries into the **“Text ID”** box only, clicking **“Add”** between each entry. Click **“Save/Close”** when finished.

Example of text as it appears in the daily note report: *“He indicates _____.”*

Examples of what you might enter to complete the above statement are: *“a recently sprained ankle”, “that he recently pulled his lower back”, or “that he recently hurt his neck”.*

Customizing “Assessment, Diagnosis” (Page 2, left, DN3c Form)

“New Additional” – “New Additional” is located under “Assessment, Diagnosis” and is typically used in conjunction with the “New Injury” bubble in the previous section. Some additional diagnosis codes are included in the program.

To add more codes to this list, follow the [eight steps on Pg. 79](#). Type all entries into both the “Text ID” and “Predefined Text” boxes, clicking “Add” between each entry. Click “Save/Close” when finished.

Example of text as it appears in the daily note report: *“It is my opinion that the patient is additionally suffering from _____.”*

An example of what you might enter to complete the above statement is: *“722.4 Cerv. Disc Degeneration”*

Customizing “Assessment, Progress” (Page 2, right, DN3c Form)

“Of Addt’l Note” – This bubble is for entering additional notes regarding the progress or status of a patient. When predefining this bubble you want to enter the text that will appear in your “pick list” into the “Text ID” box. The text will appear in the report exactly as it is entered into the “Predefined Text” box and should be entered in the form of a complete sentence.

Examples of what you might enter for “Of Addt’l Note”:

Text ID Predefined Text

Resolved – *“There is no further treatment needed for this condition.”*

Unchanged – *“There is no change in the patient’s condition at this time.”*

Improving – *“The patient is responding to treatment and some improvement has been noted.”*

“Other” – “Other” is located in the “Response to Tx in %” area of the “Assessment, Progress” section. This bubble may be used to document an increase (e.g. increase in work ability) or a decrease (e.g. decrease in hypertonicity) or to list items such as “soreness” or “edema”.

To predefine this bubble, follow the eight [steps at the top of Pg. 79](#) and type entries into the “Text ID” box only, clicking “Add” between each entry. Click “Save/Close” when finished.

Example of text as it appears in the daily note report: *“It is my observation that the response to treatment results in a 20% increase/reductions in _____.”*

Examples of what you might enter to complete the above statement: *“increase in work ability”, “decrease in hypertonicity”, “soreness”, and “edema”.*

Customizing “Today’s Treatment, Modalities” (Page 2, lower left, DN3c Form)

“Other 1”, “Other 2”, “Other 3” – These three columns allow the entry of additional modalities used in your practice. You may enter up to 99 different modalities for any of the three columns. If you choose the “Always Use” option for a modality, the system will automatically use the item when you mark a bubble in that column. You may also want to add a “Travel Card Id”. This information will appear in the “Thrpy” box on your printed travel card and should be entered as a recognizable abbreviation for the treatment or modality.

When predefining items in the “Today’s Treatment, Modalities” section, you will notice that these items must be entered in two parts; “Description” and “Expected Results”.

“Description” – After clicking **“Add”**, enter the name of the modality into the **“Text ID”** box in lowercase letters. Here you can choose a **“Travel Card ID”**. The **“Travel Card ID”** will appear on the travel card and should be a recognizable abbreviation of the modality. You may also enter the bill code for the item in this screen. Click **“Close”** when you are finished and the **“Expected Results”** screen will appear. Follow the directions in the section titled **“Expected Results”** to complete your entry.

Examples of what you might enter under “Description”:

<u>Name of Modality(“Text ID”)</u>	<u>“Travel Card ID”</u>
electrical muscle stimulation	EMS
neuromuscular re-education	NMR
cold laser	CL

“Expected Results” –In this screen, you will want to enter the results expected from administering a particular modality. Enter an abbreviation representing the name of the modality in the **“Text ID”** box. Drop down to **“Predefined Text”** and enter the expected results for the modality.

Examples of what you might enter under “Expected Results”:

<u>Modality</u>	<u>“Text ID”</u>	<u>“Predefined Text”</u>
electrical muscle stimulation	EMS	“to reduce muscle spasm and inflammation”
neuromuscular re-education	NMR	“to improve circulation and decrease muscular tension”
cold laser	CL	“to reduce pain and inflammation”

Example of text as it appears in the daily note report: *“To reduce muscle spasm and inflammation, electrical muscle stimulation is given to the upper cervical area for ten minutes.”*

Customizing “Plan” (Page 2, lower half, DN3c Form)

“Changed as Follows” – Use this bubble when you want to make adjustments to the current treatment plan. You may use this bubble by itself to change the treatment plan or in addition to **“Per Initial/Prev. Plan”** to modify the current treatment plan.

When predefining in this section, what is entered in the **“Text ID”** box is what will be visible as available predefines. What is entered in the **“Predefined Text”** box will appear once a particular item has been selected. The information will appear in your daily note report. **Examples are outlined below.**

Example of text as it appears in the daily note report: *“The current treatment approach changes as follows:_____”*

Examples of what you might enter to complete the above statement: *“Patient to receive massage 2x per week in addition to current treatment.”, “Patient to discontinue use of moist heat for home care.”*

“Other” (Additional Recommendations) – This bubble can be used for any **“Other”** additional recommendations.

When predefining in this section, what is entered in the **“Text ID”** box is what will be visible as available predefines. What is entered in the **“Predefined Text”** box will appear once a particular item has been selected. The information will appear in your daily note report. **Examples are outlined below.**

Example of what you might enter for “Other”: **“Text ID”** – *“Exercise program”*, **“Predefined Text”** – *“To improve circulation and decrease joint stiffness, it is recommended that the patient participate in some form of aerobic exercise 3 times per week.”*

“Addtl. Diagnostic Testing” – Use this bubble to document a recommendation for additional diagnostic testing. **Examples are outlined below.**

Example of text as it appears in the daily note report: “_____ is warranted for the patient.”

Examples of what you might enter to complete the above statement: “An MRI”, “A CAT scan”

“Exercise” (Home Care Instructions) – Use this bubble when prescribing home care exercise. You can create a “pick list” of home care exercise protocols. **Examples are outlined below.**

Example of text as it appears in the daily note report: “The home care procedure now includes_____.”

Examples of what you might enter to complete the above statement: “doorway stretches”, “strengthening exercises for the rhomboids”

“Other” (Home Care Instructions) – Use this bubble when entering additional home care instructions for items not listed on the daily note form. **Examples are outlined below.**

Example of text as it appears in the daily note report: “The home care procedure now includes_____.”

Examples of what you might enter to complete the above statement: “rest for thirty minutes each evening with feet elevated”, “increased water intake by 16 oz. per day”

“PRN” – This bubble can be predefined to accommodate changes in visit schedule. **Examples are outlined below.**

Example of text as it appears in the daily note report: “The patient's visit schedule is altered to_____.”

Examples of what you might enter to complete the above statement: “3x per week for 2 wks, 2x per week for 4 wks, then 1 x per week for 4 wks”, “patient to return as needed”

Customizing “Rehab Therapy” (Page 2, lower half, DN3c Form)

The entire **“Rehab Therapy”** section is user defined. When an item in this section is bubbled and the form is scanned, a query screen will appear. You can predefined specific rehabilitative therapies, stretches, and/or exercise protocols into any or all of these columns. You may enter up to 99 items in each column. In this section, the items listed across the top can be redefined in the program. However, since the printed text cannot be changed, it is our recommendation that you categorize items according to the headings that appear on the form. **For example:** Create a pick list of all cervical exercises and therapies in the **“Cervical”** column.

When predefined this area, the name of the therapy, stretch, or exercise protocol should be entered into the **“Text ID”** box and a partial sentence including the therapy and targeted area or region of the body should be entered into the **“Predefined Text”** box. **Examples are outlined below.**

Example of text as it appears in the daily note report: “_____ for ten minutes.”

Example of what you might enter in the “Text ID” box: “PNF - SCM”, strengthening–Rhomboids”, “resistance bands – wrist ext.”

Example of what you might enter in the “Predefined Text” box: “PNF stretching was performed bilaterally on the SCM muscles”, “Rhomboid strengthening exercises using 3 lb. weights were performed”, “To strengthen the wrist extensors, resistance bands were utilized”

You may also want to add a **“Travel Card Id”**. This information will appear in the **“Thrp”** box on your printed travel card and should be entered as a recognizable abbreviation for the rehab therapy performed.

Customizing “Man/Adj.” (Page 2, lower right, DN3c Form)

“Pillows” (1, 2, 3) – These bubbles can be used to enter three different therapeutic or support pillows. Information entered here will appear in the **“Plan”** section of your daily note report and be preceded by **“The following was prescribed”** or followed by **“was prescribed”**. Examples are outlined below.

Example of text as it appears in the daily note report: (Multiple items bubbled) *“The following were prescribed this session:”* **(Single item bubbled)** *“This session _____ was prescribed.”*

Examples of what you might enter to complete the above statement: *“a lumbar support pillow”, “a cervical alignment pillow”*

“Other” (1-6) – These bubbles can be used to enter nutritional supplements and other items recommended or prescribed for a patient. Information entered here will appear in the **“Plan”** section of your daily note report and be preceded by **“The following was prescribed”** or followed by **“was prescribed”**. Examples are outlined below.

Example of text as it appears in the daily note report: (Multiple items bubbled) *“The following were prescribed this session:”* **(Single item bubbled)** *“This session _____ was prescribed.”*

Examples of what you might enter to complete the above statement: *“a multivitamin”, “a calcium supplement”, “a TENS unit”*

Customizing “X-Rays” (Page 2, lower right, DN3c Form)

At the bottom of the **“X-Rays”** section you will find a bubble with an empty line beside it. You may create a pick list of any x-ray views not listed on the form. When predefining this bubble the new item should be entered into the **“Text ID”** box. For this area, it is not necessary to enter information into the **“Predefined Text”** box.

Example of text as it appears in the daily note report: *“A_____ x-ray was taken today.”*

Examples of what you might enter to complete the above statement: *“knee AP/Lat”, “hip Lat view”*

Customizing the “Technique Bars” (Page 1)

You will notice that there is a **“Technique Bar”** located in each treatment section on page 1. In the **“Thrust Report”** the technique bar is located slightly to the left of the **“TMJ”** listing box. Under **“Today’s Tx – General Listings”**, you will find one for the **“Tx1”** section, one for the **“Tx2”** section, one for the **“Upper Extremity”** column, and one for the **“Lower Extremity”** column. Within each of the technique bars you will find bubbles **“1, 2, 3”**. These bubbles are for predefining additional techniques.

You may program in up to 99 different items into the **“1, 2, 3”** bubbles. Any item predefined for a particular one of these bubbles will be available under the same number in all sections. When predefining this bubble, the new technique should be entered into the **“Text ID”** box. For this area, it is not necessary to enter information into the **“Predefined Text”** box. You may also want to add a **“Travel Card Id”**. This information will appear in the **“Adj”** box on your printed travel card and should be entered as a recognizable abbreviation for the specified technique.

Customizing “SOAPT” (1&2) (Page 1)

The “**SOAPT 1**” bubbles are for adding information to your daily note report that there is not another bubble on the form for. When predefining the “**SOAPT 1**” bubbles, information should be entered in the form of a complete sentence using capitalization and punctuation. The information will appear at the end of that particular section exactly as it was entered. **(Example:** Predefined information for the “**S1**” bubble will appear at the end of the “**Subjective**” section in your daily note report.)

The “**SOAPT 2**” bubbles are for adding in-office information that will print only on the travel card. When one of the “**SOAPT 2**” bubbles is marked on the form, and once the form is scanned, a query screen will appear prompting you to enter the information for your travel card. You may also enter additional travel card information for a patient via the patient database. See instructions below

Entering information for the “SOAPT 2” bubbles via the “Patient” database:

1. From the “**Main Menu**” click “**Databases**”. (You are now in the patient database)
2. Select the patient for whom you want to enter information. (double click or highlight and select the patient name)
3. Locate and click on the “**Notes**” tab at the top of the screen.
4. Enter information into the appropriate section(s).

With the exception of “**DN Diagnosis Codes**” in the “**Patient**” database “**Notes**” screen, **ALL** of the “**SOAPT 2**” **information**, regardless of method of entry, appears in the “**Notes**” section on your printed travel card.

If you have questions or need additional assistance with customizing the daily note form, please call the Document Plus training department at 800-642-0600.

APPENDIX B – Outcome Assessment Questionnaires

What are Outcome Assessment Questionnaires?

The healthcare and legal systems of today are moving into an era of assessment and accountability. The emerging tools for measuring the effectiveness of patient treatment procedures are the Outcome Assessment questionnaires, which offer a statement of both subjective and objective data. These questionnaires are available for your patients to fill out and provide you and your staff with assessment tools that can help establish validity, responsiveness, and reliability of treatment as well as a patient's functional status.

The Outcome Assessment questionnaires should be administered based on patient histories and your examination/re-examination findings to provide a detailed assessment of the patient's progress over time. Used properly, the **“Revised Oswestry Low Back”**, **“Roland Morris Acute Low Back”**, **“Neck Pain Disability”**, and **“Health Status Questionnaire”** forms can prove to be valuable outcome assessment tools for your practice. This section is designed to give you an understanding of what each of these forms is used for and when they should be used.

How it Works

Utilizing Outcome Assessments in your office is a simple process. First, have the patient complete the Outcome Assessment Questionnaire. Next, your staff will scan the questionnaire into the system and the data is incorporated into reports for the patient, insurance companies and/or attorneys. In a matter of minutes you will have established validity, responsiveness, and reliability of treatment.

Billing for Outcome Assessments

To properly incorporate assessment questionnaires into your normal office protocol you must be in compliance with the following: Administer the questionnaire to the patient, produce the outcome assessment report independently or as part of the report of findings, schedule a time for an outcome assessment consultation and review the report with your patient. The billable code for an initial visit is 96150 and on a subsequent outcome assessment (i.e. re-exam) the code is 96151. These are classified as Health and Behavior Assessment Codes and the description of the procedure is as follows: “An assessment of patient's condition was performed through the administration of various health and behavior assessment instruments.”

Most insurance companies will have these codes in their current database. Assuming that both the provider and the payer are following CPT guidelines and protocols, and the codes are covered services in an insurance contract and clinically needed, payment would be expected.

NOTE: These service codes are for time units of 15 minutes or less. Any forms and/or questionnaires used are considered assessment tools and are not intended as substitutes for actual professional services rendered by the doctor. Remember that you are billing for a service and not for an assessment tool.

Three Easy Steps

Implementing and billing for Outcome Assessments can be done in three easy steps. The process of implementing the use of Outcome Assessments should consist of the following three steps:

1. Administer the questionnaire – Have the patient fill out the appropriate questionnaire.
2. Scan the questionnaire and create the report – After the patient has completed the questionnaire, scan it and generate the related outcome assessment report.

NOTE: Information from questionnaires administered on the Initial visit will appear in the “**Initial Report of Findings**” document. Information from questionnaires administered on a subsequent visit can be generated by selecting “**Outcome Measures**” in the “**Generate Documents**” screen or by generating “**re-eval**” or “**final**” narratives.

3. Review the outcome assessment with the patient – After generating the report, schedule a time when you will review the findings with the patient. This is typically done on the visit following an initial examination or re-evaluation.

What to remember...

- Establish a time when “**Health and Behavior Assessment**” consultations will be held in your office. These are typically done on the visit following an initial examination or re-evaluation..
- Only use “**Health and Behavior Assessment**” codes when a patient presents a problem.
- You are billing for a service and not the assessment tool.

You can find additional information regarding Health and Behavior Assessment codes in the ChiroCode “Hot Topics” Newsletter. <http://www.docplus.net/training/chirocode.pdf>

Getting Started

Outcome Assessment questionnaires should be administered on the patient’s initial visit and at each re-evaluation. Each questionnaire and associated patient complaints are outlined below.

Neck Pain Disability Index Questionnaire - This assessment is designed to measure the activities of daily living in persons with neck pain. *Use when patient complains of: headaches, neck pain, upper shoulder pain, upper back pain*

Roland Morris Acute Low Back Pain Disability Questionnaire – This form is designed to be a simple and accurate measure of assessing back pain and disability. *Use when patient complains of: Acute low back pain (4 weeks or less)*

Revised Oswestry Chronic Low Back Pain Disability Questionnaire – This is a subjective questionnaire that quantifies the degree of functional impairment of individuals with chronic low back pain. The Oswestry is a well known outcome assessment tool used in evaluating the effectiveness of treatment protocols. *Use when patient complains of: Chronic low back pain (more than 30 days)*

Health Status Questionnaire – This questionnaire measures eight specific health attributes grouped under three major health dimensions; functional status, well being, and overall health. It is used to show overall functional status and is commonly used in personal injury and wellness cases. *To establish a baseline of overall health, the Health Status Questionnaire should be incorporated as part of the routine exam on each new patient, and then administered again at each re-evaluation.*

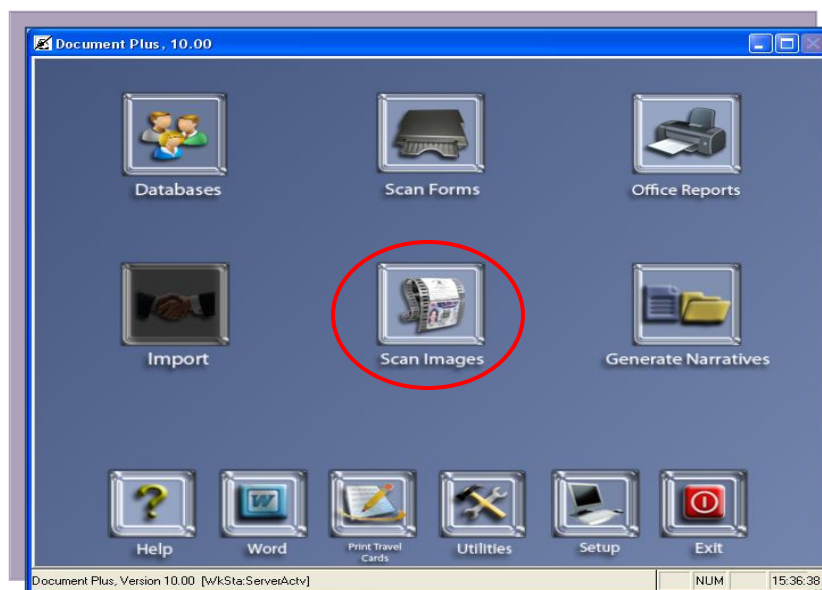
APPENDIX C – Scanning Images

With the “**Scan Images**” feature, you are able to create electronic “**Records**” for your patients. You have the ability to scan copies of a patient’s driver license, insurance card, medical records from another office, or any other document you want to keep on file.

Scan Images or Records

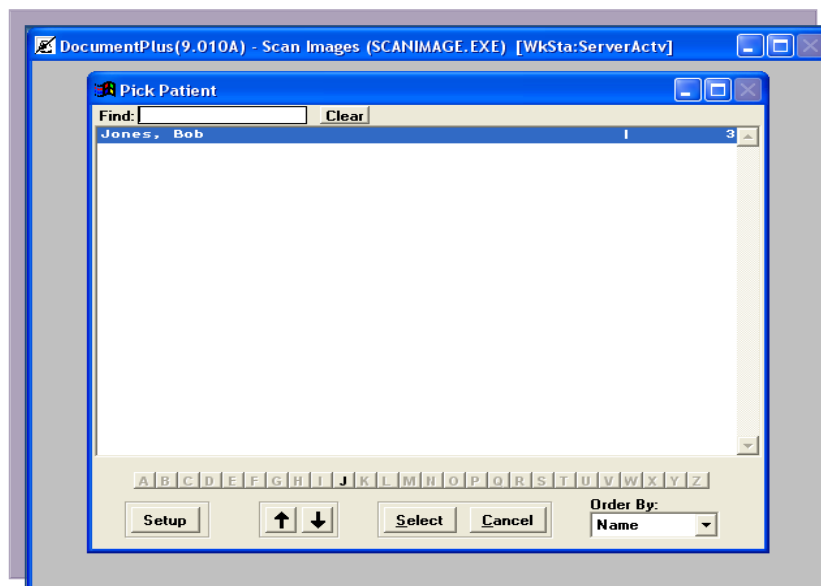
1. On the “**Main Menu**” click the lower half of the “**Scan**” button next to “**Images**”. (See Figure 1 below)

Figure 1 – “Main Menu”



You are now in the “Pick Patient” screen. (See Figure 2 below)

Figure 2 – “Pick Patient” screen



2. Select the name of the patient you are scanning images for.

You are now in the “New Medical Record” screen. (See Figure 3 below)

Figure 3 – “New Medical Record” screen

3. Enter the “New Medical Record Name” in the area provided at the bottom of the “New Medical Record” screen. In Figure 3 above, “CPI” (Confidential Patient Information) has been entered.
4. Click “Scan” at the bottom of the screen.
5. Scan the document (make sure it is face-up)

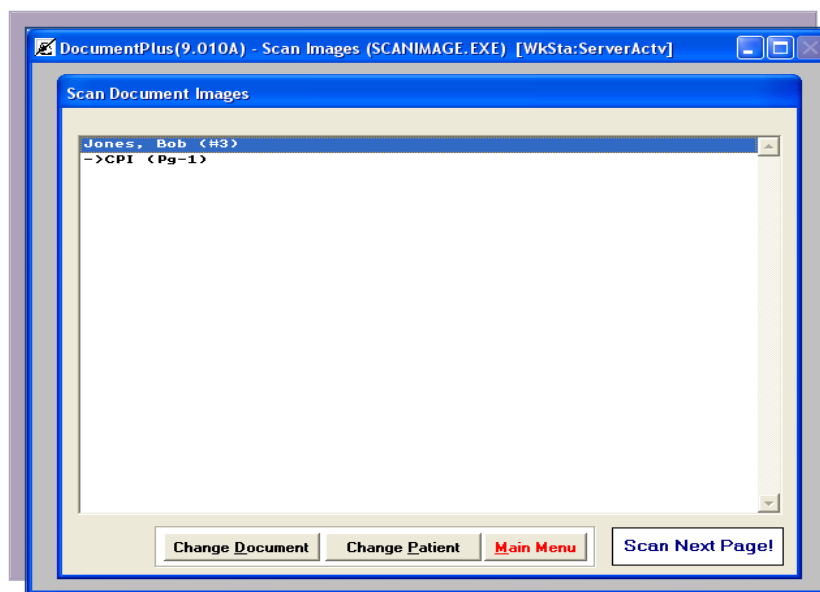
You are now in the “Scan Image” screen. Your document now appears and you will notice that the “New Medical Record Description” entered in Step 3 above is shown at the top of your screen. (See Figure 4 below)

Figure 4 – “Scan Image” screen

Using the toolbar at the right of the “**Scan Image**” screen, you have a number of options. These options are outlined below.

“**Save**” – Clicking “**Save**” saves the document and takes you back to the “**Scan Document Images**” screen. (Shown below in Figure 5)

Figure 5 – “Scan Document Images” screen



Options in the above screen allow you to:

- Scan another page for the current document
- Choose a different existing document to scan additional pages for – Highlight the document in the “**Medical Records on File**” section and scan the additional page(s).
- Create a new document – Click “**New Document**” to create a new document listing for the current patient.
- Create a “**New Medical Record**” for a different patient – Click “**New Patient**” to choose a different patient to scan records for from your patient database.
- Exit – Clicking “**Exit**” will return you to the “**Main Menu**”.

“**Ignore**” – Clicking “**Ignore**” dismisses the previously scanned document without saving, and returns you to the “**Scan Document Images**” screen. Options in this screen are listed above. (See “**Save**”)

“**Flip**” – This feature allows you to rotate the current document 180°.

“**Change Patient**” – Clicking “**Change Patient**” will take you back to the “**Pick Patient**” screen where you can select another patient to scan images for.

“**Change Document**” – By clicking “**Change Document**”, you can either select an existing document to add pages to or create a new document record for the current patient.

“**Exit**” – Clicking “**Exit**” in this screen will return you to the Main Menu.

Access and Edit Images (when not in “Scan” mode)

To locate images and records that you have previously scanned:

1. From the “Main Menu”, click “Generate Documents”.
2. Select the patient from the “Pick Patient” screen. (If there are no forms scanned for the selected patient you may access scanned images and records by clicking “Utilities” on the main menu, clicking “Print Medical Records” and choosing the desired patient.)

You are now in the “Generate Documents” screen. (See Figure 6 below)

Figure 6 – “Generate Documents” screen

3. Click “Records” under the “Controls” heading.

You are now in the “Print Medical Records – Select Record File” screen. (Shown in Figure 7)

Figure 7 – “Print Medical Records – Select Record File” screen

4. Select “CPI” from the available list. (See Figure 7, Pg. 90)

You are now in the “Print Medical Records” screen.

Figure 8 – “Print Medical Records” screen

DocumentPlus(9.010A) - Document Generation (DOCUMENT.EXE) [WkSta:ServerActv]

Print Medical Records | Jones, Bob (#3) | CPI [Page # 1 of 2]

CONFIDENTIAL PATIENT INFORMATION DATE ____/____/____
PLEASE PRINT

PATIENT INFORMATION:
FULL NAME: Bob Jones DATE OF BIRTH: 10/5/52 AGE: ____ Male ☒ Female ☐
ADDRESS: 123 Main St. APT# ____ SSN: 555 55 5555
CITY: Atlanta STATE: GA ZIP CODE: 30022 HOME PHONE: 770 814-2424
ALTERNATE PHONE (CELL): (____) _____ EMAIL ADDRESS: _____
EMPLOYER'S NAME: ABC Company OCCUPATION: Salesman
WORK ADDRESS: 234 State St. CITY: Atlanta STATE: GA ZIP: 30022
WORK PH # 770 555-7676 EXT: _____ DATE SYMPTOMS BEGAN: ____/____/____
MARITAL STATUS: SINGLE ☐ MARRIED ☒ WIDOWED ☐ HOW DID YOU HEAR ABOUT US? _____
EMERGENCY CONTACT: _____ PHONE: _____

CLAIM INFORMATION:
IS YOUR CONDITION DUE TO: AN AUTO ACCIDENT ☐ A PERSONAL INJURY ☐ A WORK INJURY ☐ OTHER ☐
TYPE OF CLAIM: CASH ☐ GROUP HEALTH INS ☐ PERSONAL INJURY ☐ WORKER'S COMP ☐ MEDICARE ☐
I WILL BE PAYING TODAY BY: CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER ☐ OTHER ☐

INSURANCE INFORMATION:
RELATIONSHIP TO INSURED? SELF ☒ SPOUSE ☐ OTHER ☐ CHILD ☐ SPOUSE: _____
INSURED'S EMPLOYER SAME AS ABOVE ☒ _____
INSURED'S SSN SAME AS ABOVE ☒ SSN: _____ INSURED'S DOB SAME AS ABOVE ☐ _____
PRIMARY INSURANCE CO: All Cities Ins. ADDRESS: 400 State St.
CITY: Atlanta STATE: GA ZIP CODE: 30022 PHONE#: _____
POLICY NUMBER: 240 GROUP NUMBER: 2255
SECONDARY INSURANCE CO: _____ ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____ PHONE#: _____
POLICY NUMBER: _____ GROUP NUMBER: _____

AUTHORIZATIONS:
A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.
Patient's Signature: Bob Jones Date: 2/1/12
Guardian Signature: _____ Date: _____

Print Page
Print All
Next Page
Prev. Page
Flip
Change Patient
Change Document
Exit

Options in this screen allow you to:

- “Print Page” - Print the current page.
- “Print All” - Print all pages for the current document.
- “Next Page” – View the next page(s) in the current document.
- “Previous Page” – Return to the previous pages in the current document.
- “Change Document” – View a different document for the existing patient.
- “Zoom” – Enlarge the page currently visible on the screen.
- “Flip” – Rotate the current document 180°.
- “Exit” – Return to the “Generate Documents” screen.
- “Crop Width”/”Crop Height” – Crop the page currently visible on the screen.

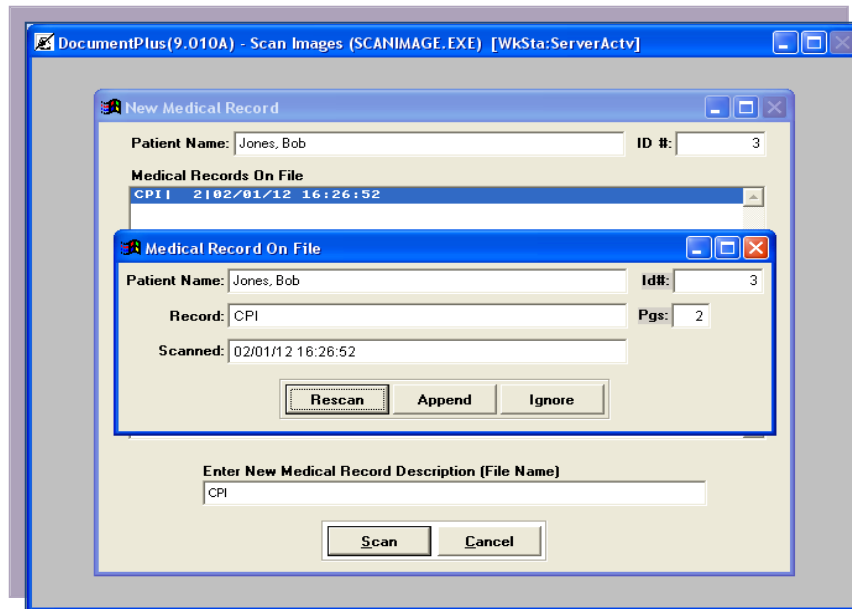
Append or Rescan a Record

Follow the steps below to replace a record or add pages to an existing record.

1. From the “Main Menu” click “Scan Images”.
2. Select a patient from the “Pick Patient” list.
3. Select the record you wish to replace or append from the list of available documents and click “Scan”.

The “Medical Record On File” screen now appears. (Shown in Figure 9 below)

Figure 9 – “Medical Record On File” screen



In this screen you have the option to “**Rescan**” or “**Append**” the current document.

- If you choose “**Rescan**” you will receive a prompt asking if you want to delete the current record.
 - If you choose “**Yes**” the record will be deleted and the “**Scan Document Images**” screen will appear so that you may “**Rescan**” the document.
 - If you choose “**No**” you will be returned to the “**New Medical Record**” screen.
- If you choose “**Append**”, the “**Scan Document Images**” screen will appear so that you may scan additional pages for the selected document.
- If you choose “**Ignore**” you will remain in the “**New Medical Record**” screen.

Delete a Record

Follow the steps below to delete an existing record.

1. From the “**Main Menu**” click “**Generate Documents**”.
2. Select a patient from the “**Pick Patient**” list.
3. Once in the “**Generate Documents**” screen click “**Records**”. The “**Print Medical Records – Select Record File**” screen will appear. (See Figure 7, Pg. 90)
4. Select the record you wish to remove and click “**Delete**” at the bottom of the screen.

If you have further questions regarding scanning images and medical records using the Document Plus system please contact the training department at 800-642-0600.

APPENDIX D – P.A.R.T. for Medicare

P= PAIN

A=ASYMMETRY
B= RANGE OF MOTION

R=RANGE OF MOTION

T=TEMP, TONE, TONICITY

Using the acronym P.A.R.T., the five diagnostic criteria for spinal dysfunction (subluxation) are identified as follows:

Pain/Tenderness (P)	
1	None
2	Mild
3	Moderate
4	Severe

The perception of pain and tenderness is evaluated in terms of location, quality, and intensity. Most primary neuromusculoskeletal disorders manifest primarily by a painful response. Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, etc. Furthermore, pain intensity may be assessed using one or more of the following: Visual Analog Scales, algometers, pain questionnaires, etc.

Documented on our DN FORM in the symptoms section (PG2). The 5 columns in the symptoms section represent what Medicare wants to know about the symptoms (Beginning in the 1st column we have the TYPE of problem, SEVERITY of the problem, CHARACTERISTICS, FREQUENCY, and WHETHER OR NOT THE PROBLEM IS IMPROVING). Also documented using the PAIN SCALE (VAS) and the PAIN DIAGRAMS. *** FROM THE DOCTOR'S EXAM – Document in the objective section using the TENDER and RADIATE columns under biomechanical exam (PG1).

Figure 1 – “Symptoms, Section1”, DN3c Form, Pg. 2

SYMPTOMS If Your Symptoms HAVE NOT Changed Since Your Last Visit Indicate Here ☐ And Proceed To Section II

SECTION I If Your Symptoms HAVE Changed Since Your Last Visit Please Complete Both Sections I and II

TYPE OF PROBLEM	RIGHT SIDE	SEVERITY OF PROBLEM	CHARACTERISTICS OF PROBLEM	FREQUENCY OF PROBLEM	WHETHER IMPROVING OR NOT
	Pain Tingling Numbness Stiffness Boredness Swelling Weakness	Mild Moderate Severe	Burning Dull Sharp Shooting Stinging Throbbing	Occasional Intermittent Frequent Constant	Improving Worsening Unchanged Reserved
Head					
Neck					
Upr Back					
Mid Back					
Low Back					
Shoulder					
Elbow					
Wrist					
Hand					
Hip					
Knee					
Ankle					
Foot					

SECTION II

How Would You Rate Your Pain Today With
0 Being The Best And 10 Being The Worst

PAIN SCALE (VAS)

No Pain Worst Pain Possible

If Your Symptoms Change, When Are They Worse

☐ Morning ☐ Evening ☐ Afternoon

☐ Night ☐ Other

PAIN DIAGRAM Please Mark The Location Of Your Pain On These Figures

PATIENT SIGNATURE AND DATE

☐ No New Aggravation / Injury

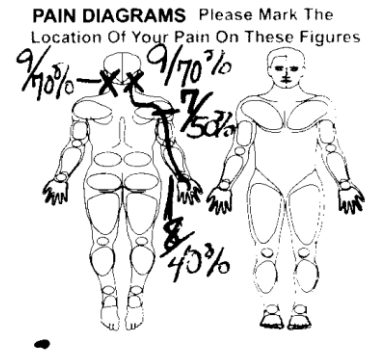
☐ New Injury

PATIENT SIGNATURE: **DATE:**

Figure 2 – “Subjective” section, Daily Note report – Sample Text

SUBJECTIVE

Bob Jones indicates during his visit this day that his main complaints are the following: The patient has in both sides of his neck a frequent sharp, shooting pain with stiffness and soreness of a severe level. In the right shoulder he is bothered by an intermittent pain with stiffness and soreness of a moderate degree. The patient is experiencing in the right wrist a frequent throbbing pain with swelling of a moderate level. He says that in both sides of his neck and right shoulder there is no change in the pain with stiffness and soreness. In his right wrist the pain with swelling is unchanged. On a visual analog scale of 0 to 10 with 0 being no pain and 10 being the worst pain possible, the patient reports his overall pain is an 8. He relates that his symptoms are worse in the morning. The patient notes that he has not had any new provocative incident.



PATIENT SIGNATURE: *Bob Jones* DATE: *1-31-08*

Figure 3 – “Objective” section, “Biomechanical Exam”, DN3c Form, Pg.1

OBJECTIVE		Same Assessment	
Leg Length Deficiency		Equal	
Left	Right	Left	Right
10	10	10	10
9	9	9	9
8	8	8	8
7	7	7	7
6	6	6	6
5	5	5	5
4	4	4	4
3	3	3	3
2	2	2	2
1	1	1	1
0	0	0	0

Biomechanical Exam			
	Sublux	Tender	Rotate
LEFT			
RIGHT			
U			
M			
L			
U			
M			
L			
U			
M			
L			
S			
P			
U			
L			

Range Of Motion		Pain	
	Decreased	Normal	Mild Moderate Severe
Cervical			
Dorsolumbar			

Figure 4– “Objective” section, Daily Note report – Sample Text

OBJECTIVE

The following conclusions are indicated by a palpatory evaluation of the cervical spine and right upper extremity: Apparent pain to palpation is noted overlying the left upper cervical spine. Tender musculatures are located at the right upper cervical area which radiates. Pain to palpation is detected in the left middle cervical range. Pain to palpation is present specific to the right middle cervical area which radiates. Pain to palpation is apparent specific to the left lower cervical region. Tender muscles are evident specific to the right lower cervical spine which radiates. Evidence of tenderness is identified in the right upper extremity.

Asymmetry/Misalignment (A)

This criterion may be identified on a sectional or segmental level through one or more of the following: observation (posture and gait analysis), static palpation for misalignment of vertebral segments, diagnostic imaging, etc.

Documented on our DN FORM in the objective section (PG 1). LEG LENGTH DEFICIENCY, POSTURE, and FORWARD FLEXION all show asymmetry or misalignment.

Figure 5 – “Objective” section, “Leg Length Deficiency”, “Posture”, “Forward Flexion”

OBJECTIVE ☐ Same Assessment

Leg Length Deficiency ☐ Equal

	1/8	1/4	3/8	1/2	5/8	3/4	7/8	1 1/8	1 1/4	1 3/4	2
Left											
Right											

Posture

	L	R
Head Tilt		
High Shoulder		
High Hip		
Antalgia		

Forward Flexion

	Cervical	Lumbar
Pain		
Increased		
Normal		
Mild		
Moderate		
Severe		

Range Of Motion

	Cervical	Dorsolumbar
Decreased		
Normal		
Mild		
Moderate		
Severe		

Figure 6 – “Objective” section, Daily Note report – Sample Text

OBJECTIVE

The evaluation of the disparity in the length of the legs confirms the right leg to be 1/8 of an inch short reflective of postural compromise. Analysis of his posture substantiates the head tilted to the right with forward flexion in the cervical spine.

Range of Motion (R)

Changes in active, passive, and accessory joint movements may result in an increase or a decrease of sectional or segmental mobility. Range of motion abnormalities may be identified through one or more of the following: motion palpation, observation, stress diagnostic imaging, range of motion measurement(s), etc.

Documented on our DN FORM in the “objective” section under “RANGE OF MOTION”.

Figure 7 – “Objective” section, “Range of Motion”

OBJECTIVE		○ Same Assessment	
Leg Length Deficiency		○ Equal	
Left	18 16 14 12 10 8 6 4 2	18 16 14 12 10 8 6 4 2	
Right			
Biomechanical Exam			
LEFT	sublux Spasm Tender Inflam Irradiate	sublux Spasm Tender Inflam Irradiate	RIGHT
	U	U	
	M	M	
	L	L	
	U	U	
	M	M	
	L	L	
	U	U	
	M	M	
	L	L	
	S	S	
	P	P	
	U	U	
	L	L	
○ High Hip		○ Pain	
○ Antalgia		○	
Range Of Motion		Decreased Normal Mild Moderate Severe	
Cervical	●	●	●
Dorsolumbar	○	○	○
Dorsolumbar	○	○	○

Figure 8 – “Objective” section, Daily Note report – Sample Text

OBJECTIVE

Cervical ranges-of-motion are diminished with severe pain, corresponding with clinical evaluation.

Tissue Tone, Texture, Temperature Abnormality (T)

Changes in the characteristics of contiguous and associated soft tissues including skin, fascia, muscle, and ligament may be identified through one or more of the following procedures: observation, palpation, use of instrumentation, tests of length and strength, etc.

Documented on our DN FORM in the “objective” section under “BIOMECHANICAL EXAM” using the “SPASM” and “INFLAMMATION” columns.

Figure 9 – “Objective” section, “Biomechanical Exam”

The image shows a sample Biomechanical Exam form. It is a grid with columns for 'LEFT' and 'RIGHT' sides, and rows for 'Upper', 'Middle', and 'Lower' cervical spine ranges. Each cell contains a small diagram of a person's head and neck. Red circles highlight the 'Spasm' and 'Inflammation' columns for both sides. The 'Range of Motion' column is also visible, with 'U' for upper, 'M' for middle, and 'L' for lower. The form is titled 'Biomechanical Exam' at the top.

Figure 10 – “Objective” section, Daily Note report – Sample Text

OBJECTIVE

During the palpatory evaluation of the cervical spine, spastic deep paraspinal musculatures are present overlying the left upper range. There is spasm and edema noted specific to the right upper cervical spine. Spastic deep paraspinal musculatures are detected at the left middle cervical area. Myospasm and inflammation are located in the right middle cervical range. Myospasm is apparent at the left lower cervical area. Spastic and inflamed musculatures are evident specific to the right lower cervical spine. Cervical ranges-of-motion are diminished with severe pain, corresponding with clinical evaluation.

Summary

To ensure the medical necessity of treatment, Medicare requires that at least two of the four elements of PART be documented. It is also required that one of those two be either the asymmetry/misalignment or the range-of-motion abnormality. (Acceptable documentation of PART would include the "A" with "P," "R," or "T"; or the "R" with the "P," "A," or "T"; or just the "A" and the "R," but never just the "P" and the "T.")

If practitioners standardize their evaluation, comparisons of treatment effectiveness and efficiency are possible. PART is not meant to be a replacement for all joint evaluation procedures as there are testing procedures that are specific to a technique system (leg check, arm fossa test, therapy localization, etc.). Additionally, visceral relationships should be considered, as well as other testing procedures deemed necessary from data previously obtained.

***This document is for informational purposes only and is not intended to be a conclusive outline of Medicare requirements. For conclusive information please review the Medicare documentation guidelines for your state.

References:

http://findarticles.com/p/articles/mi_qa3841/is_199912/ai_n8856567/pg_2
http://www.chiropub.com/issues/articles/2006-02_06.asp

APPENDIX E – Clinical Evaluation #3 - INSTRUCTIONS

This section is designed to offer explanations regarding the Clinical Evaluation #3 (CE3) Form and how to properly complete the form. The following instructions cover the form section by section. It is our recommendation that you refer to the CE3 form while reviewing these instructions.

The Clinical Evaluation can be used as a Re-Evaluation form as well. Choose the appropriate bubble at the top of the form. If a bubble is not selected, the system will look to see what forms you have on file and select it for you. [If there is no previous CE on file the program will assume that the unmarked form is an initial CE (clinical evaluation). If there is a previous CE on file the program will assume that the unmarked form is an RE (clinical re-evaluation).]

NOTE 1: Only marked bubbles/sections will appear in the written report. If you skip a section, nothing will be written in the report “automatically”. For example, if you want a test to be described as “Negative” in the written reports, it must be marked as negative on the form or nothing will be written.

NOTE 2: “Queries” are discussed in the User Manual. These are responses that the programs expects you the user to input from information or findings that you have gathered and hand written on the form. You can set the system up to always use the same response each time you choose the bubble for a query. You may also enter multiple entries to create a “pick list” for a particular bubble. If you have any questions after reviewing the “Queries” section in this manual, please feel free to contact our training staff at 800-642-0600.

SECTION A – “Physical Examination”

“A1”.....Demeanor:

- Make one selection for “**Coherent**” or “**Incoherent**”.
- Make one choice for “**Distressed**” (“**Mild**”, “**Moderate**”, “**Severe**”).
- If you choose “**Relaxed**” you cannot choose the “**Nervous**”, “**Agitated**”, or “**Disinterested**” bubbles.
- If you bubble “**Other**”, all other bubbles will be ignored as the information you enter in the “query” will supersede any other thing marked in the section.

“A2” -“A7”.....Vital Signs:

If “**All Vitals Stable**” is marked, the written report will reflect that the patient’s vitals are stable, but will not give specific numbers. You may mark this bubble and still use “**A2**”-“**A7**” to document specific numbers. For example the report will look like this:

Vital Signs	All Stable
Height:	5' 10"
Weight:	220 pounds
Temperature:	98.6°F
Pulse:	60/minute and regular
Respiration Rate:	15/minute

“A2”, Height: Mark one bubble for **“Feet”** and one for **“Inches”**.

“A3”, Weight: Mark one bubble per line for **“Hundreds”**, **“Tens”**, and **“Units”**.

“A4”, Temperature: Mark one bubble per line. **“Pnts.”**= Points in temperature. (Ex. 98.6)

“A5”, Pulse: Choose either **“Regular”** or **“Dysrhythmic”**. One bubble per line for **“Hundreds”**, **“Tens”**, and **“Units”**.

“A6”, Respiration Rate: Choose one bubble per line for **“Tens”**, and **“Units”**.

“A7”, Blood Pressure:

- Choose the position in which the pressure was obtained; **“Seated”**, **“Standing”**, **“Supine”**.
- Use either **“Left”** or **“Right”**, but not both.
- Bubbles must be filled in for both **“Systolic”** and **“Diastolic”**.
- Mark only one bubble per line for **“Hundreds”**, **“Tens”**, and **“Units”**.

“A8”–“A16”.....For questions **“A8”–“A16”** choose either the **“Normal Finding”** or **“Abnormal”**.
“WNL” = Within Normal Limits. **“Abnormal”** findings, if bubbled, will generate a query.

“A17”..... Peripheral Circulation:

“A17a” - “Arterial Pulses”:

- Both right and left must be marked.

For reference: 0=absent, 1=diminished, 2=normal, 3=full, 4=bounding.

“A17b” - “Lower Extremity Venous”:

- Choose either **“WNL”** or any of the other objective finding choices, but not both.
- The **“Other”** bubble if marked supersedes all the other bubbles.

“A18”..... “Of Additional Note”: You can enter information for these nine bubbles each time you want to add additional information or you can predefine lists of customized entries to choose from.

“A19”..... “Medical Records”: You can enter information for these nine bubbles each time you want to add additional information or you can predefine lists of customized entries to choose from.

SECTION B – “Posture Examination”

“B1”..... Observations:

- **“Body Type”:** Choose one bubble
- **“Presentation”:**
 - Choose **“Erect”** or something else in the section, but not both.
 - Choose **“Left”** or **“Right”**.
 - There can only be one choice for **“Slight”**, **“Moderate”**, or **“Severe”**.
- **“Ambulation”:**
 - Choose either **“Normal”**, **“With Assistance”**, or **“Non-Ambulatory”**. You may only choose one.

- There can only be one choice for “**Slight**”, “**Moderate**”, or “**Severe**”.
- “**General**”: Choose either “**Left**” or “**Right**” for all items here. For “**Winged Scapula**” both “**Left**” and “**Right**” may be marked.
- “**Cervical**”: You may only mark one choice for “**Left**” or “**Right**”, one choice for “**Anterior**” or “**Posterior**”, and one choice for “**Flexion**” or “**Extension**”.
- “**Torso**”: You may only mark one choice for “**Left**” or “**Right**”, one choice for “**Anterior**” or “**Posterior**”, and one choice for “**Flexion**” or “**Extension**”.
- “**Pelvis**”: You may only mark one choice for “**Left**” or “**Right**”, one choice for “**Anterior**” or “**Posterior**”, and one choice for “**Flexion**” or “**Extension**”.
- “**Feet**”: You may only mark one choice for “**Pronation**” or “**Supination**”, one choice for “**Hyper**”, “**Hypo**”, or “**Pes Planus**”, and only one choice for “**Foot Inversion**” or “**Eversion**”.

“**B2**”..... “**Leg Length Deficiency**”:

- Marking “**Legs Balanced**” supersedes any other bubble marked in this section.
- Choose either “**Left**” or “**Right**” and one choice for measurement.
- You may combine “**Supine**”, “**Prone**”, etc.
- “**Cervical Dependant**” and “**Pelvic Dependant**” cannot be combined.

“**B3**”..... “**Orthopedic Tests**”:

“**B3a**” - “**Adam’s Sign**”

- For “**Adam’s Sign**” either “**Positive**” or “**Negative**” may be marked, but not both.
- “**Functional Scoliosis**” or “**Structural Scoliosis**” may be marked, but not both.
- “**Sciatica**” may be marked for both the “**Left**” and “**Right**”.

“**B3b**” - “**Minor’s Sign**”

- “+”=Mild, “++”=Moderate, “+++”=Severe.

“**B4**”..... “**Of Additional Note**”: You can enter information for these twelve bubbles each time you want to add additional information or you can predefine lists of customized entries to choose from.

SECTION C – “**Neurological Assessment**”

“**C1**”..... “**Cerebrovascular Function**” (Sections a, b, and c, = George’s Test)

- “**Carotid Pulsations**”: Can mark both “**Left**” and “**Right**”. “**2**”= Normal
- “**Bruits**”: Can mark both “**Left**” and “**Right**”.
- “**Craniocervical Functional Maneuver**” or “**Maignes Test**”: Can mark both “**Left**” and “**Right**”. If you select “**Findings**”, you will need to enter those findings as a query.

“**C2**”..... “**Cranial Nerves**”:

- If you mark the “**Cranial Nerves Intact / Except**” bubble, you do not have to mark anything else in the section and the report will reflect that all 12 Cranial nerves are intact. However, if you find all are normal with the exception of one or two, you can also mark the “**Cranial Nerves Intact/Except**” bubble and select up to TWO abnormal nerves.
- The “**Findings**” bubbles correspond with the Cranial Nerve numbers and all require query text to be entered.

“**C3**”..... “**Cerebellar Function**”:

- **“Gait”**: The **“Normal”** bubble supersedes anything else marked in the section. You may only mark ONE of the remaining choices.
- **“Rapidly Alternating Movements”**: You may mark both **“Left”** and **“Right”**. **“Quickly and Accurately”** = “Normal” for the test and supersedes any other bubbles marked.
- **“Heel to Shin”**: You may mark both **“Left”** and **“Right”**. **“Quickly and Accurately”** = “Normal” for the test and supersedes any other bubbles marked.
- **“Romberg’s Test”**: You may only mark one choice for **“Negative”** or **“Positive”**.
- **“Finger to Finger”**: **“Smoothly and Easily”** = “Negative and normal”. You cannot mark **“Smoothly and Easily”** and **“Positive”** for the test.
- **“Finger to Nose”**: **“Smoothly and Easily”** = “Negative and normal”. You cannot mark **“Smoothly and Easily”** and **“Positive”** for the test.
- **“Other 1”**: A **“Negative”** and **“Positive”** bubble is provided for you to add in your own tests. Please see explanation of queries and predefined text for explanation.
- **“Other 2”**: A **“Negative”** and **“Positive”** bubble is provided for you to add in your own tests. Please see explanation of queries and predefined text for explanation.

“C4”..... “Deep Tendon Reflexes”:

- Both **“Left”** and **“Right”** may be marked.
- If you mark the **“Grade 2 and Symmetric/Except”** bubble, you do not have to mark anything else in the section and the report will reflect that all upper or lower nerve root **“Deep Tendon Reflexes”** are intact. However, if you find all are normal with the exception of one or two, you can also mark the **“Grade 2 and Symmetric/Except”** bubble then select up to TWO abnormal reflexes.

For Reference: 0=Absent, 1=Hypoactive, 2=Normal, 3=Hyperactive without Clonus, 4=Hyperactive with Clonus, 5=Tonic

“C5”..... “Motor Examination”:

- **“Upper Extremity Motor Function”:**
 - Both **“Left”** and **“Right”** may be marked.
 - If you mark the **“No Muscle Weakness/Except”** bubble you do not have to mark anything else in the section, and the report will reflect that all upper nerve root motor functions are grade 5/5 and intact. However, if you find all are normal with the exception of one or two, you can also mark the **“No Muscle Weakness/Except”** bubble and select up to TWO abnormal functions.
- **“Lower Extremity Motor Function”:**
 - Both **“Left”** and **“Right”** may be marked.
 - If you mark the **“No Muscle Weakness/Except”** bubble, you do not have to mark anything else in the section and the report will reflect that all upper nerve root motor functions are grade 5/5 and intact. However, if you find all are normal with the exception of one or two, you can also mark the **“No Muscle Weakness/Except”** bubble and select up to TWO abnormal functions.

For Reference: 0/5=No muscle movement, 1/5=Visible movement (twitch), but no movement at the joint, 2/5=Movement at the joint, but not against gravity, 3/5=Movement against gravity, but no added resistance, 4/5=Movement against gravity and resistance, but less than normal, 5/5=Normal strength.

“C6”.....“ Mensuration”: Mark only one choice per line for **“Tens”** and **“Units”**.

“C7”..... “Dermatomal Sensory Testing”:

- This part of the test is divided into four separate sections corresponding to Cervical, Thoracic, Lumbar, and Sacral dermatomes.
- You may use as many sections as needed or none at all.
- In any of the four sections, you have the option of marking the **“No Sensory Deficit/Except”** bubble, and do not have to mark anything else in the section. The report will reflect that all dermatomes listed in that particular section normal and intact. However, if you find that all dermatomes are normal with the exception of one or two, you can mark the **“No Sensory Deficit/Except”** bubble and choose the deficiencies found.
- Both **“Left”** and **“Right”** may be marked for a given Dermatome, but both **“Hypo”** and **“Hyper”** may not be marked for the same Dermatome on the same side.

“C8”..... “Heel Walk”: **“Able to Perform”** = Negative and normal. You may not mark both this choice and **“Unable to Perform”**, which indicates a positive finding for the test.

“C9”..... “Toe Walk”: **“Able to Perform”** = Negative and normal. You may not mark both this choice and **“Unable to Perform”**, which indicates a positive finding for the test.

“C10”..... “Plantar Response”:

- You may mark both **“Left”** and **“Right”**.
- **“Plantar Flexion”**=Normal cannot be marked with any other option.

“C11”..... “Hoffman’s Sign”:

- You may mark both **“Left”** and **“Right”**.
- Only one choice may be marked for **“Negative”** or **“Positive”**, but not both.

“C12”..... “Dynamometer”:

- Both **“Left”** and **“Right”** may be marked, but only one choice for **“Hundreds”(H)**, **“Tens”(T)**, or **“Units”(U)** may be marked per side.
- You may choose to bubble one **“Attempt”** or all three.
- The system will average together your findings and the report will list each individual attempt and give an average or the findings for the attempts.

“C13”..... “Of Additional Note”: You can enter information for these nine bubbles each time you want to add additional information or you can predefine lists of customized entries to choose from.

SECTION D – “Orthopedic Exam of the Spine”

“D1”..... “Cervical Spine”:

- **“Range of Motion” (D1a):**
 - If you mark the **“Normal In All Positions/Except”** bubble, you do not have to mark anything else in the section. The report will reflect that all ranges of motion in the cervical spine are normal and the normal degrees will be listed. If you find that all ranges of motion are normal with the exception of one or two, you can mark the **“Normal In All Positions/Except”** bubble and choose the deficiencies found. You may also just mark a particular range of motion tested and skip the rest.

- The numbered bubbles in each of the ranges listed represent degrees.
- **“Tens”** may be combined with **“Units”**.
- Though it is not required, if you choose to mark the bubbles for additional descriptors associated with the range of motion, you may choose either **“Dull Pain”** or **“Sharp Pain”** and not both.
- If you mark either **“Spinal Level Of:”** or **“Radiates To:”** a query will appear. The query must be answered for the system to complete the report.
- **“Cervical Muscle Testing” (D1b):**
 - Both Left and Right may be marked. If you mark the **“No Muscle Weakness/Except”** bubble, you do not have to mark anything else in the section. The report will reflect that all cervical muscle groups listed on the form were tested and were found to be grade 5/5 and intact. If you find all are normal with the exception of one or two, you can also mark the **“No Muscle Weakness/Except”** bubble and select up to TWO abnormal findings.

For Reference: 0/5=No muscle movement, 1/5=Visible movement (twitch), but no movement at the joint, 2/5=Movement at the joint, but not against gravity, 3/5=Movement against gravity, but no added resistance, 4/5=Movement against gravity and resistance, but less than normal, 5/5=Normal strength.

- **“Compression Tests” (D1c):**
 - **“Cervical Compression Test” (D1c1):**
 - You may choose to mark the **“Negative In All Positions/Except”** bubble and the report will reflect that all positions were tested and found to be normal. If you find that all compression tests are normal with the exception of one or two, you can mark the **“Negative In All Positions/Except”** bubble and choose the deficiencies found.
 - There may only be one choice for **“Negative” (-)** and **“Positive” (+)**.
 - You may mark either **“Dull” (Pain)** or **“Sharp”** but not both.
 - **“Left”** and **“Right”** may both be marked.
 - There is also a bubble for the descriptor **“Paresthesia”** that may be added.
 - There are additional bubbles in this section of Cervical, Shoulder, Arm, Hand/Fingers.
 - One or all of these bubbles may be marked and are used to indicate where pain was produced in association with the test or where the pain radiated to. For example: If you mark **“Cerv+Shldr+Arm”**, the report will state that the test produced pain in the cervical spine that radiated to the patients shoulder and arm.
 - **“Adson’s Test” (D1c2):**
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Both **“Left”** and **“Right”** may be marked.
 - The down arrow indicates a decrease in Pulse.
 - **“Valsalva” (D1c3):**
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Both **“Left”** and **“Right”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test, but if the **“Other”** bubble is marked, it supersedes all other options and a query will be generated.

- **“Stretch Tests” (D1d):**
 - **“Shoulder Depression” (D1d1):**
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Both **“Left”** and **“Right”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test, but if the **“Other”** bubble is marked, it supersedes all other options and a query will be generated.
 - **“Soto Hall” (D1d2):**
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Both **“Left”** and **“Right”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test, but if the **“Other”** bubble is marked, it supersedes all other options and a query will be generated.
- **“Distraction Tests” (D1e):**
 - **“Cervical Distraction”, “Bakody’s Sign”, and “O’Donoghue’s” tests:**
 - Only one choice of either **“Negative”** or **“Positive”** may be marked.
 - Both **“Left”** and **“Right”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test, but if the **“Other”** bubble is marked, it supersedes all other options and a query will be generated.
 - In the case of these tests, a **“Positive”** = alleviating pain during the test.
- **“Other 1” (D1f): “Negative” and “Positive”** bubbles are provided for you to add in your own tests. Please see explanation of “Queries” and “Predefined text”.
- **“Other 2” (D1g): “Negative” and “Positive”** bubbles are provided for you to add in your own tests. Please see explanation of “Queries” and “Predefined text”.
- **“Other 3” (D1h): “Negative” and “Positive”** bubbles are provided for you to add in your own tests. Please see explanation of “Queries” and “Predefined text”.
- **“Of Additional Note” (D1i):** You can enter information for these twelve bubbles each time you want to add additional information or you can predefine lists of customized entries to choose from.

“D2”..... “Thoracic Spine”:

- **“Range of Motion” (D2a):**
 - If you mark the **“Normal In All Positions/Except”** bubble, you do not have to mark anything else in the section and the report will reflect that all ranges of motion in the thoracic spine are **“Normal”** and the **“Normal”** degrees will be listed. If you find that all ranges of motion are normal with the exception of one or two, you can mark the **“Normal In All Positions/Except”** bubble and choose the deficiencies found. You may also just mark a particular range of motion tested and skip the rest.
 - The numbered bubbles in each of the ranges tested represent degrees and **“Tens”** may be combined with **“Units”**.
 - Though it is not required, if you choose to mark the bubbles for additional descriptors associated with range of motion, there can be only one choice of **“Dull Pain”** or **“Sharp Pain”**.
 - If you mark the bubbles for **“Spinal Level Of:”** or **“Radiates To:”** queries will appear. They must be answered for the system to complete the report.

- **“Thoracic/Torso Muscle Testing” (D2b):**
 - Both **“Left”** and **“Right”** may be marked.
 - If you mark **“No Muscle Weakness/Except”** you do not have to mark anything else in the section and the report will reflect that all thoracic/torso muscle groups listed on the form were tested and were found to be grade 5/5 and intact. If you find all are normal with the exception of one or two, you can mark **“No Muscle Weakness/Except”** bubble and select up to TWO abnormal findings.

For Reference: 0/5=No muscle movement, 1/5=Visible movement (twitch), but no movement at the joint, 2/5=Movement at the joint, but not against gravity, 3/5=Movement against gravity, but no added resistance, 4/5=Movement against gravity and resistance, but less than normal, 5/5=Normal strength.

- **“Mechanical Tests” (D2c):**
 - **“Chest Expansion Test” (D2c1):**
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - A decrease in inches must be indicated.
 - **“Sternal Compression Test” (D2c2):**
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - A query will be generated for you to indicate the location of the pain produced.
 - **“Beavor’s Sign”:**
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
 - There can be only one choice for **“Superior Movement”** or **“Inferior Movement”**.
- **“Stretch Test” (D2d):**
 - **“Shepelmann’s Sign”:**
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Both **“Left”** and **“Right”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
 - There can be only one choice of either **“Concave”** or **“Convex”**.
- **“Other 1” (D2e):** **“Negative”** and **“Positive”** bubbles are provided for you to add in your own tests. Please see explanation of “Queries” and “Predefined text”.
- **“Other 2” (D2f):** **“Negative”** and **“Positive”** bubbles are provided for you to add in your own tests. Please see explanation of “Queries” and “Predefined text”.
- **“Other 3” (D2g):** **“Negative”** and **“Positive”** bubbles are provided for you to add in your own tests. Please see explanation of “Queries” and “Predefined text”.
- **“Of Additional Note” (D2h):** You can enter information for these thirteen bubbles each time you want to add additional information or you can predefine lists of customized entries to choose from.

“D3”.....”Lumbar Spine”:

- **“Range of Motion” (D3a):**
 - If you mark **“Normal In All Positions/Except”** you do not have to mark anything else in the section and the report will reflect that all ranges of motion in the lumbar spine are normal and the normal degrees will be listed. If you find that all ranges of motion

are normal with the exception of one or two, you can mark **“Normal In All Positions/Except”** and choose the deficiencies found.

- You may also just mark a particular range of motion tested and skip the rest.
- The numbered bubbles in each of the ranges tested represent degrees and **“Tens”** may be combined with **“Units”**.
- Though it is not required, if you choose to mark the bubbles for additional descriptors associated with range of motion, there can be only one choice of **“Dull Pain”** or **“Sharp Pain”**.
- If you mark the bubbles for **“Spinal Level Of:”** or **“Radiates To:”** queries will appear. These must be answered for the system to complete the report.

NOTE: There is no **“Rotation”** of the lumbar spine.

- **“Compression Tests” (D3b):**

- **“Valsalva” (D3b1):**

- Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Both **“Left”** and **“Right”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
 - If the **“Other”** bubble is marked, it supersedes the rest and a query will appear.

- **“Iliac Compression Test (D3b2):”**

- Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Both **“Left”** and **“Right”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
 - If the **“Other”** bubble is marked it supersedes all other options and a query will appear.

- **“Kemp’s Test” (D3b3):**

- Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Both **“Left”** and **“Right”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
 - There can be only one choice marked for either **“Leaning Into”** or **“Leaning Away”**.

- **“Mechanical Tests” (D3c):** (SI=Sacroiliac)

- **“FABERE-Patrick’s Test”:**

- Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.

- **“Gaenslen’s Test”:**

- Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.

- **“Thomas Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
- **“Yeoman’s Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
- **“Hibb’s Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
- **“Goldwaith’s Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
 - Only one choice may be marked for either **“SI”** or **“Lumbar”** but not both.
- **“Trendelenberg’s Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of either **“Negative”** or **“Positive”** may be marked.
- **“Root Tension Signs” (Stretch Tests) (D3d):**
 - **“Straight Leg Raise Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
 - There can be only one choice for degrees at which pain was produced; (0-30, 35-70, 70-90).
 - If the **“Other”** bubble is marked, it supersedes all other options and a query will appear.
 - **“Braggard’s Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
 - There can be only one choice for degrees at which pain was produced; (0-30, 35-70, 70-90).
 - If the **“Other”** bubble is marked, it supersedes all other options and a query will be generated.
 - **“Well Leg Raise Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.

- Additional bubbles may be marked to indicate where pain was produced during the test.
 - There can be only one choice for degrees at which pain was produced; (0-30, 35-70, 70-90).
 - If the **“Other”** bubble is marked, it supersedes all other options and a query will be generated.
- **“Fajersztajn’s Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
 - There can be only one choice for degrees at which pain was produced; (0-30, 35-70, 70-90).
 - If the **“Other”** bubble is marked, it supersedes all other options and a query will be generated.
- **“Kernig’s Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
 - There can be only one choice for degrees at which pain was produced; (0-30, 35-70, 70-90).
 - If the **“Other”** bubble is marked, it supersedes all other options and a query will be generated.
- **“Sitting Leg Raise Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
 - There can be only one choice for degrees at which pain was produced; (0-30, 35-70, 70-90).
 - If the **“Other”** bubble is marked, it supersedes all other options and a query will be generated.
- **“Milgram’s Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
- **“Ely’s Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
- **“Nachlas Test”:**
 - Both **“Left”** and **“Right”** may be marked.
 - Only one choice of **“Negative”** or **“Positive”** may be marked.
 - Additional bubbles may be marked to indicate where pain was produced during the test.
- **“Other 1” (D3e):** **“Negative”** and **“Positive”** bubbles are provided for you to add in your own tests. Please see explanation of **“Queries”** and **“Predefined text”**.

- **“Other 2” (D3f): “Negative” and “Positive”** bubbles are provided for you to add in your own tests. Please see explanation of “Queries” and “Predefined text”.
- **“Other 3” (D3g): “Negative” and “Positive”** bubbles are provided for you to add in your own tests. Please see explanation of “Queries” and “Predefined text”.
- **“Of Additional Note” (D3h):** You can enter information for these thirteen bubbles each time you want to add additional information or you can predefine lists of customized entries to choose from.

SECTION E – “Spinal Examination”

The spinal examination section is essentially broken down into two sections with **“Edema”**, **“Spasm”**, and **“Tenderness”** grouped together as to how they are reported and **“Trigger Points”**, **“Articular Fixation”**, and **“Malposition”** grouped together in their reporting.

In the systems set-up menu you can choose to have the group that includes **“Edema”**, **“Spasm”**, and **“Tenderness”** reported by individual levels that you mark. For example: “Edema at the C1 and C3 levels”, or you can set the system to report by region (U=Upper, M=Middle, L=Lower) for example if you mark same as the previous C1 and C3, the report will state that Edema was found overlying the upper and middle cervical regions. You may choose L=Left, M=Middle, or R=Right for any given level. Additionally, Tenderness has bubbles labeled 1-4 that you may choose to further indicate the “Grade” of tenderness elicited during the exam. For example a Grade 4=Worst tenderness.

The sections that report Trigger Points, Articular Fixation, and Malposition cannot be grouped by upper, middle, or lower region and will be reported by the specific spinal level indicated. Additionally, by default if Articular Fixation or Malposition is checked, the report will say just that without the word “Subluxation” added. However, if you would like the system to use the term, go to set-up menu and look under spinal examination for the CE3 and check the box that indicates adding the term “Subluxation” to the report. For example without the box checked the report will say “a malposition was found at the T1 level.” With the box checked, the report will say “a subluxation malposition was found at the T1 level.”

Finally, as with the other sections on the form, there are two bubbles at the end of each section labeled as “None” and “Note” (Cervical, Thoracic, Lumbar, Sacro-pelvic). If “None” is marked for a particular section, then the report will reflect for example: “No edema, spasm, or tenderness was found over the upper, middle, or lower regions of the cervical spine”. “Note” is also at the end of each section to enable you to add an additional note or finding to the specific spinal region, a query will be generated.

“Algometer”: If this section is used, you must indicate on the form if the readings were taken in PSI or Kgs./cm. Anything marked in this section will prompt you to enter the information via the query screens.

SECTION F – “Extremity Evaluation”

Both sections for the **“Upper Extremities”** and **“Lower Extremities”** are driven entirely by query input. Any bubble marked will generate a query so that you may enter an explanation of your findings. They must be entered for the system to complete the report.

SECTION G – “Assessment”

In this section, you may mark as many diagnoses as you feel necessary to complete your report. You may choose only one and designate the diagnosis as either “**Primary**”, “**Secondary**”, or “**Other**”. The “**Other**” designation is used for Medicare in which case if marked, you may designate a condition as something other than “**Primary**” or “**Secondary**” such as “**Co-Morbidity**”. You may choose further descriptors of your diagnosis to be listed on the report such as “**Acute**”, “**Sub acute**”, or “**Chronic**”, or “**Mild**”, “**Moderate**”, or “**Severe**”. In either case, only one choice may be bubbled and the report would reflect the following, for example:

307.81 Tension Headache.....Acute, Severe.

SECTION H – “Plan – Recommended Management”

“H1”.....“Treatments”:

- “**Manual Therapies**” (H1a):
 - Any combination of bubbles may be marked for the section.
 - Marking “**Myofascial Release**”, “**Joint Mobilization**”, or the “**Other**” bubbles will all generate a query that must be answered to complete the report.
- “**Physical Modalities**” (H1b):
 - Any combination of bubbles may be marked for the section.
 - Marking “**Cryotherapy**”, “**Diathermy**”, “**Thermotherapy**”, or “**Ultrasound**” will cause the system to display an automatic “pick-list” of further descriptors that must be chosen.
- “**Rehabilitation Recommendations-In Office**” (H1c):
 - This section is entirely query driven. Anything bubbled will generate a Query asking for an input as to what rehabilitation you will be performing.

“H2”..... “Treatment Goals”:

- You may choose one or more answers.
- The “**Other**” bubble supersedes anything else marked in the section.

“H3”..... “Visit Frequency”:

- In this section the “**From**” and “**To**” bubbles were added for ASHP users.
- “**PRN**”= As Needed.
- Per “**Day/Week**” will indicate the frequency. “**Weeks/Months**” will indicate the duration of your treatment plan. Only once choice may be marked for each. For Example: if you bubbled “3 for Week” and “2 for Months” the report will read: “The patient will be seen 3 times per week for 2 months.”

“H4”..... “Visits This Plan”:

- This section is for ASHP or HMO users. There can be only one choice for “**Tens**” and “**Units**”.

“H5”..... “Work Status”:

- This section is used if you want the report to indicate what the patient’s current status is as to being able to return to work or able to return to work with restrictions.
- If you check anything under “a.” other than “**Unable**” you must complete section “b.” as well.
- In this case, the “**Other**” bubbles in section “b.” do NOT supersede the other answers but are used to add additional restrictions or qualifications.

“H6”..... “Home Duties Restrictions”:

- This section is used if you want the report to indicate any home duty restrictions.
- The “**Other**” bubble does NOT supersede the other answers but is used to add additional restrictions or qualifications.

“H7”..... “Rehabilitation for Home Use”:

- This section is used if you want the report to indicate any rehabilitation measures you want the patient to perform while at home.
- Anything bubbled in this section will generate a query for you to enter the information.

“H8”..... “Recommendations”:

- This section is available if you want the report to indicate what further measures of referrals you intend for the patient.
- Only once choice of “R=Referral” or “I=Immediate” may be marked for any one item. For example if you marked an “I” for “Urinalysis”, and an “R for “MRI Examination” the report would indicate: “The patient will immediately undergo a Urinalysis. Additionally the patient will be referred for an MRI Examination to further assess the nature of his/her condition.”
- There are also additional bubbles that are query driven if you want to indicate that “**Medications**” or “**Supplements**” were prescribed for the patient.

“H9”..... “Case Description/Discussion” (Any Additional Info):

- This section is used if you want the report to indicate any additional information regarding the patient such as an Impairment rating or Permanent Disability.
- Any bubble may be indicated in the section, but it is query driven and the information must be either input or predefined.

“H10”..... “Prognosis”:

- This section is used if you want the report to indicate the patient’s prognosis.
- Only one choice may be marked and “**Other**” supersedes other responses.

“H11”..... “All general measure associated with condition have been reviewed.”:

- If you mark this bubble, this exact sentence will be added to the report.

“H12”..... “Potential risks have been described and the patient has acknowledged their understanding of them.”

- If you mark this bubble, this exact sentence will be added to the report.

General Notes

1. When you are using the “**CE3**” as a Re-Evaluation form, make sure that you have a daily note on file for the same day. This will cover the subjective section for the Re-Evaluation reports.
2. Every Orthopedic test can have only a “**Negative**” or “**Positive**” finding, not both.
3. Any bubble on the form that says “**Except**” can generally have only 2 exceptions with a warning.
4. PAIN MODIFIERS: on this form, when a test is marked as “**Positive**” you have a choice of having the report indicate the level of pain experienced by the patient (+=Mild, ++=Moderate, +++=Severe). If you want the modifiers added to the report, you must go into the system’s set-up screen from the Main Menu and check the box for pain modifiers to be added. If you do not check this box in the set-up screen, the report will only indicate “**Pain**” as a positive finding. If you do have modifiers enabled the report will add the modifier before “pain”. For example: “the test produced moderate pain”.

CLINICAL EVALUATION 3 / CLINICAL RE-EVALUATION 3

REFERENCE SOURCES

The CE3/RE3 was built using a cross-reference, compilation of the following reference books:

****NOTE:** No one test came from a specific source. Each test was cross-referenced between each of the sources listed below and the most agreed upon definition used for the forms. Some additional texts were used for other areas.

- DeGowin & DeGowin’s Diagnostic Examination
- Mazion’s Illustrated Reference manual of Othro/Neuro/Physio Clinical Diagnostic Techniques
- Cipriano’s Photographic Manual of Regional Orthopaedic and Neurological Tests
- Hoppenfeld’s Physical Examinaion of the Spine & Extremities
- Mosby’s Guide to Physical Examination
- Ombregt, Bisschop, Veer, and Van de Velde’s A System of Orhopaedi Medicine
- AMA Guides to Guides to Evaluation and Permanent Impairment, 5th Edition.

APPENDIX F – “List” Functions

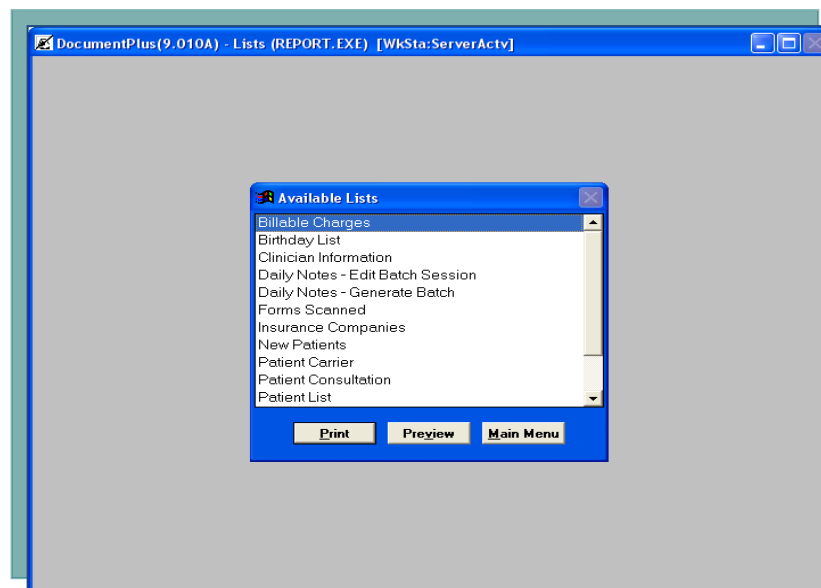
In the upper right corner of the Main Menu you will notice a button labeled “List”. This section outlines the available functions of the “List” feature.

Follow the instructions below to access the “List” feature:

1. From the Main Menu click “List”.

The “Available Lists” screen will appear. (Shown below in Figure 1)

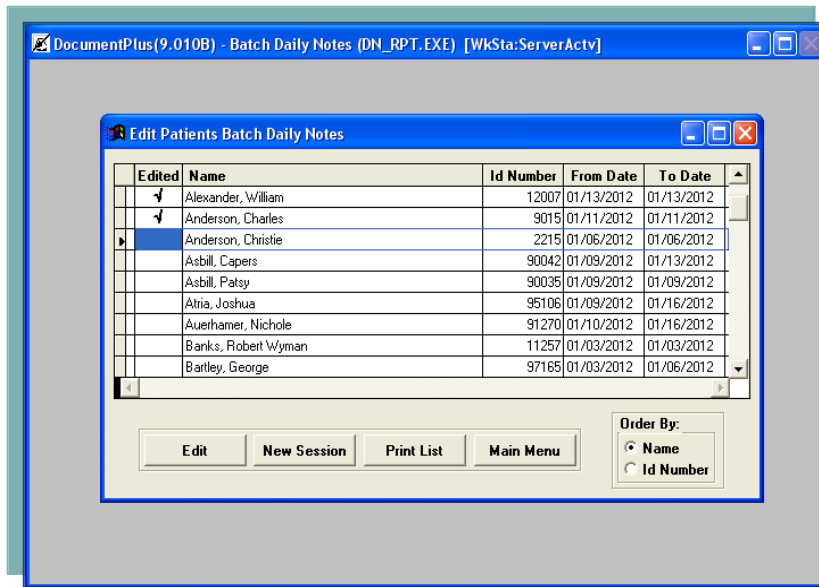
Figure 1 – “Available Lists” screen



Functions of each item in the “Available Lists” screen (above) are outlined below.

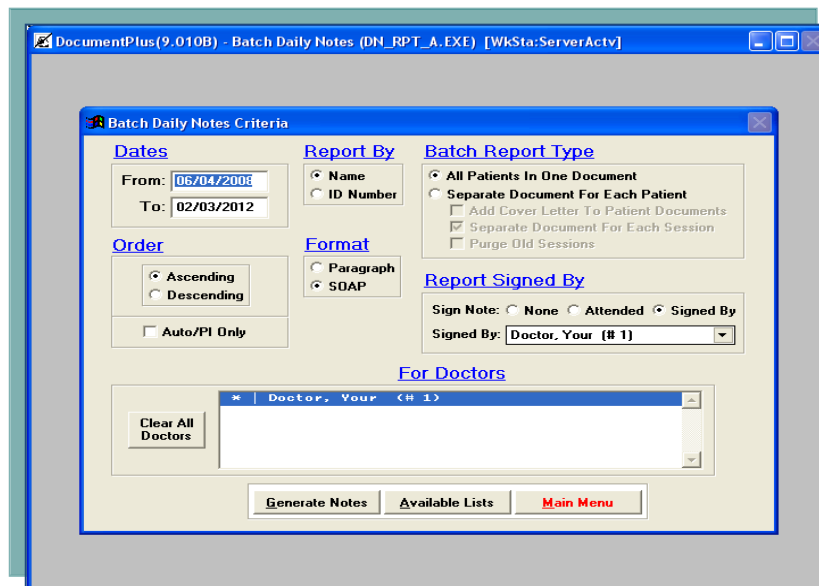
- **“Billable Charges”** - This feature enables you to preview or print a copy of all billable charges for a specific date, a range of dates, or a specific patient.
 - After selecting “Billable Charges” by date you can check the “Assessment” box to include a list of initial diagnosis codes for each patient appearing in your report.
 - If “New Injury” has been marked on a daily note form, this report will list the date the “New Injury” was indicated.
 - When a “New Injury” is indicated the report will print the text, “Update Box 14”. This is to serve as a reminder to update the appropriate field on your HCFA form.
- **“Birthday List”** – This feature enables you to generate a list of patient birthdays for a specific month.
 - If “Deceased” is checked in the patient database “Information 1” screen, the patient will not appear in the birthday list.
- **“Clinician Information”** – This feature enables you to generate a list of contact information for doctors (In-house, personal, referred to, and referred from) and attorneys in your databases.

Figure 2 – “Edit Patients Batch Daily Notes” screen



- **“Daily Notes – Edit Batch Session”** – When generating batch daily notes, you can use this feature to edit a single daily note within the batch. This feature will generate a separate note for each patient and allow you to edit a specific note by selecting it from a list.

Figure 3 – “Batch Daily Notes Criteria” screen



- **“Daily Notes – Generate Batch”** – This feature enables you to generate batch daily notes.
 - Generate by a range of dates, patient name, or patient number.
 - You have the option of including all patients in a single document or generating a separate document for each patient.

- **“Forms Scanned”** – This feature enables you to print a list of scanned forms for a specific date or range of dates.
 - Generate by **“scan date”** or **“exam date”**.
 - Sort by **“DP Number”** or **“Patient Name”**.
- **“Insurance Companies”** – This feature enables you to generate a list of contact information for insurance companies listed in your database.
- **“New Patients”** – This feature allows you to generate a list of new patients for a specific date range.
 - The report will organize the above information by the doctor seen and the visit date.
- **“Patient Carrier”** – This feature enables you to generate a list of insurance companies and the patients that are covered by them.
 - This list is sorted alphabetically by insurance company and lists patients covered under each company.
- **“Patient Consultation”** – This feature enables you to generate a list of consultation dates by patient.
- **“Patient List”** – This feature enables you to generate detailed information for a specific patient.
 - Information in this report includes Patient Name, Address, Phone Number, date the patient entered the practice, consultation date, begin treatment date, treatment phase, primary and secondary insurance carrier.
- **“Referred From Clinicians”** – This feature enables you to generate a list of clinicians who have referred patients to you.
- **“Referred To Clinicians”** – This feature enables you to generate a list of clinicians you have referred patients to.
- **“Treatment Phases”** –

If you have further questions regarding the **“List”** features please contact the training department at 800-642-0600.

APPENDIX G – “Utilities” Functions

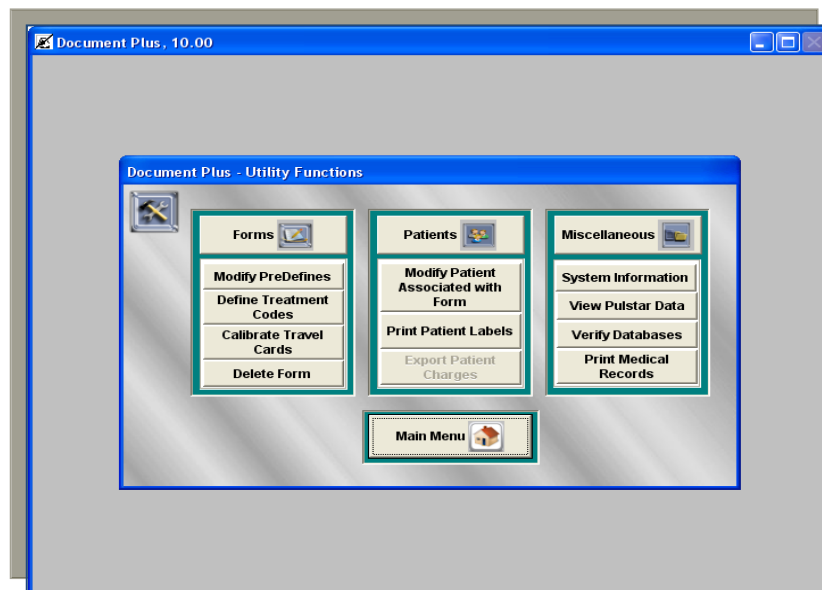
The “**Utilities**” button is located on the menu bar at the bottom of the Main Menu. This section outlines the available functions of the “**Utilities**” feature.

Follow the instructions below to access the “**Utilities**” menu.

1. From the Main Menu click “**Utilities**”.

The “**Utility Functions**” menu will appear. (Shown below in Figure 1)

Figure 1 – “Utility Functions” screen



Functions of each item in the “**Utility Functions**” screen (above) are outlined below.

- “**Purge Patients**” – “**Purge Patient**” criteria are set according to the number of days in the “**Inactive Patient Months**” field in the “**Miscellaneous 1**” setup screen. When utilizing this function, if there are patients in your database that match the preset criteria they will be listed here and you will have the option to delete the patients on the list.
- “**Verify Databases**” – This function enables you to scan all databases for system errors. To run this function all other users must close the Document Plus program.
- “**Modify Patient Associated with Form**” – In the case that you scan a form with the wrong patient number bubbled, this function allows you to assign the form to the correct patient.
- “**Delete Form**” – This function enables you to delete a specific form from a patient’s database. Once a form is deleted it cannot be rescanned.

- **“Modify Predefines”** – This function opens the **“Predefs – Select From”** screen through which you are able to access, customize, and modify the user defined bubbles on various forms. (For additional information see **“Customizing Queries”**, Pages 33-36)
- **“Print Travel Cards”** – This button opens the **“Print Travel Cards”** screen. Here you may select patients for whom you wish to print travel cards for.
- **“Calibrate Travel Cards”** - This function enables you to adjust travel card alignment, select a default printer for printing travel cards, and set pre-print preferences for “doctor number”, “patient number”, and “date”.
- **“Export Patient Charges”** – If, in the **“Settings”** screen, your system is set to export charges to your interfaced billing software manually, you will need to use this function to transfer the charges. If you do not have interfaced billing software, this button will appear gray in color and will not be available for use. The option is also available to manually export charges using a date range.
- **“Define Treatment Codes”** – This function allows you to pre-set the billing codes for various items on the daily note form (DN3, DN4) that will be transferred from your Document Plus system to an interfaced billing program. **NOTE: If your practice management (billing) software utilizes “short codes” or “office codes” you will need to make sure you enter those codes instead of the standard CPT codes.**
- **“Print Patient Labels”** - This function enables you to print mailing labels for patients by name, ID number, last activity, or birth date.
- **“View PulStar Data”** – If you are a PulStar user, this function enables you to view the data that is being imported into Document Plus from PulStar. The numbers represent stiffness in the patient’s vertebrae. If the PulStar interface is enabled the imported information will be printed on the DN3 form next to each corresponding vertebral level.
- **“Print Medical Records”** – This function enables you to access, edit, and print scanned images and records for a selected patient. **NOTE: When using this function you can access scanned records and images even if you have no forms scanned for the selected patient.**
- **“Export CBP Data”** – This feature will be used in the future for research and development purposes.
- **“Main Menu”** – Use this button to return to the main menu.

APPENDIX H – “Include Images” from the Radiographic Form (RD2)

The Radiographic (RD2) form allows you the option of adding your radiographic images to your documentation. Follow the instructions below to utilize this feature.

1. With a digital camera (flash turned off), take a picture of your X-Ray image while it is up on your view box.
2. Plug the camera in to your computer. If a camera wizard program appears you will want to cancel it. If you get a screen that says “**what do you want to do**” click “**take no action**”.
3. Find the drive letter of the camera that the pictures are on. (See instructions below)
 - Click “**My Computer**”. Look for a drive that says “**removable drive/disk**”. Once you locate the drive make note of the drive letter, close “**My Computer**” and open Document Plus.
4. Scan your forms, including the Radiographic (RD2) form and check to make sure to mark the “**Include Images**” bubble at the top left of the RD2 form. Once the forms are scanned, press “**Enter**” or click “**Documents**” to go to the “**Generate Documents**” screen for that patient.
5. Select the desired report and click “**Generate**”. Once the query screens for the Radiographic form appear, you will be prompted to locate your X-Ray images. (See Figure 1 below)

Figure 1 – “Locate RD Image Files” screen

DocumentPlus(9.010A) - Document Generation (DOCUMENT.EXE) [WkSta:ServerActv]

Locate RD Image Files

Patient: Jones, Bob(#3) Exam Date: 01/12/2012

View Image	Region	View	Status
	Cervical	AP	Missing
	Cervical	Lateral	Missing
	Thoracic	AP	Missing
	Lumbosacral	AP	Missing

Select Crop Exit Find Remove

Rotate Left Rotate Right

Clinical Evaluation Initial Re-Eval Final Clear

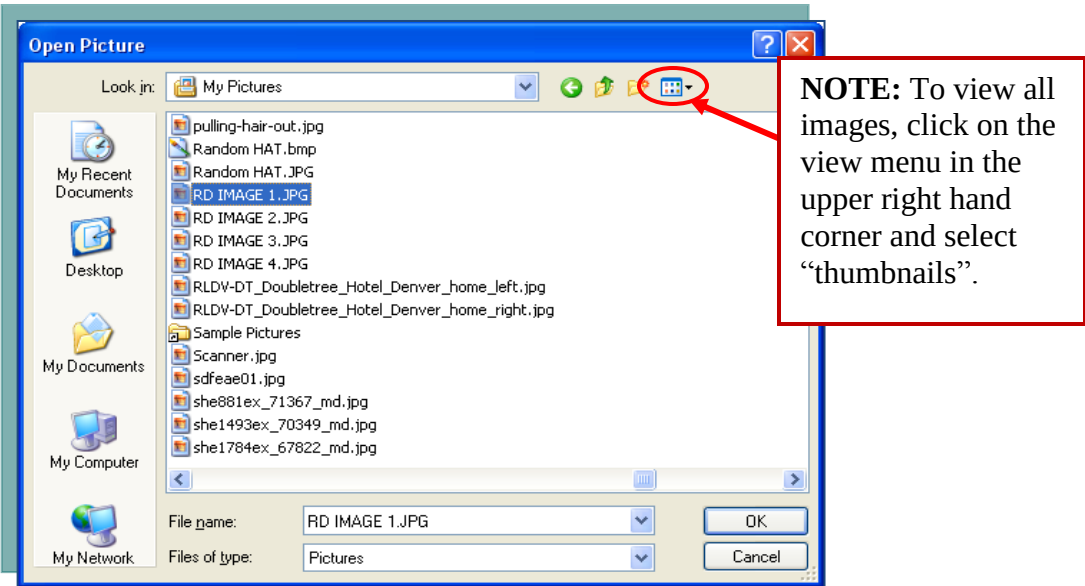
Narrtv (c:\docplus9.010\doc\docs\narrtv.dbf) Record: 79478/171629 Record Unlocked NUM 10:53:52

Repeat Steps 6-8 below for each view listed here.

6. Highlight an item in the “**Locate RD Image Files**” screen and click “**Find**” in the lower right corner of the screen to locate the desired image on your computer.

A “Locate Image File” screen will appear. (Shown in Figure 2 below)

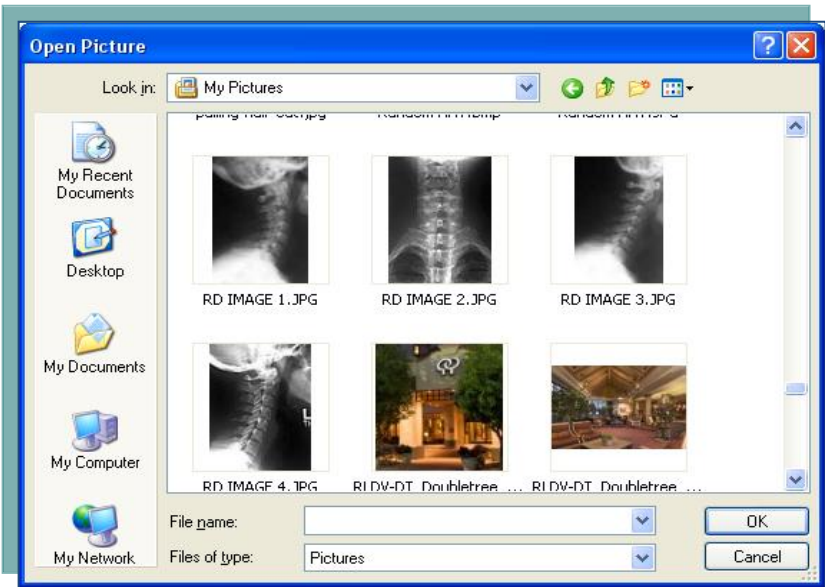
Figure 2– “Locate Image File” screen, “List” view



- 7. To view images, click on the view menu in the upper right corner of the “Locate Image File” screen and select “thumbnails”. (Shown in Figure 2 above)

The previously listed images will now appear as thumbnail sized images. (Shown in Figure 3 below)

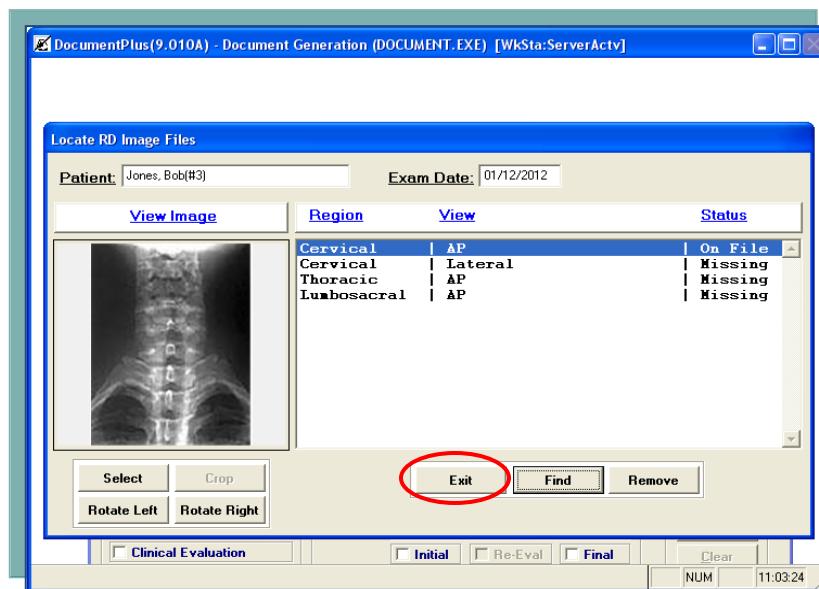
Figure 3 – “Locate Image File” screen, “Thumbnail” view



- 8. Select the desired image and click “OK”.

You are now in the “Locate RD Image Files” screen. The image should appear in the left portion of your screen. Click the “Select” button in the lower left portion of your screen.

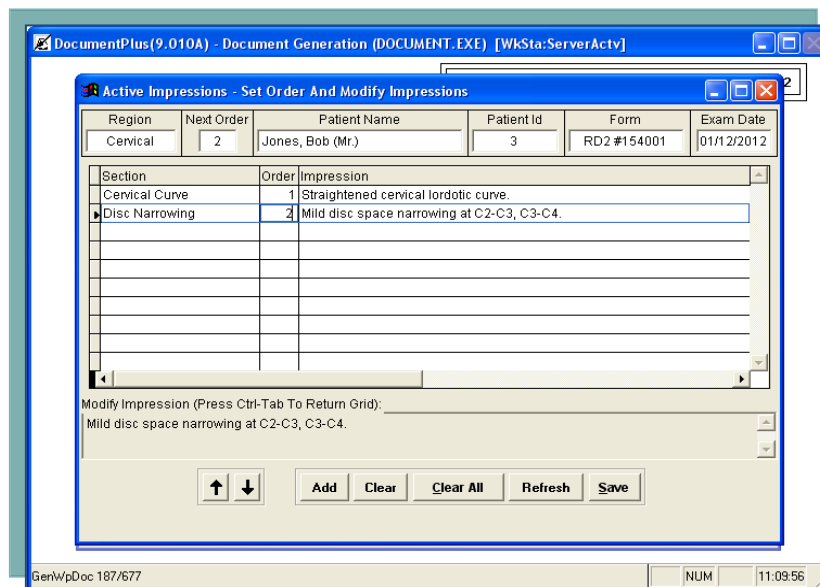
Figure 4 – “Locate RD Image Files” screen



- 9. Click “Exit” in the lower right portion of your screen. (Shown in Figure 4 above)
- 10. Repeat steps 6 through 9 for each Region/View you want in your report.

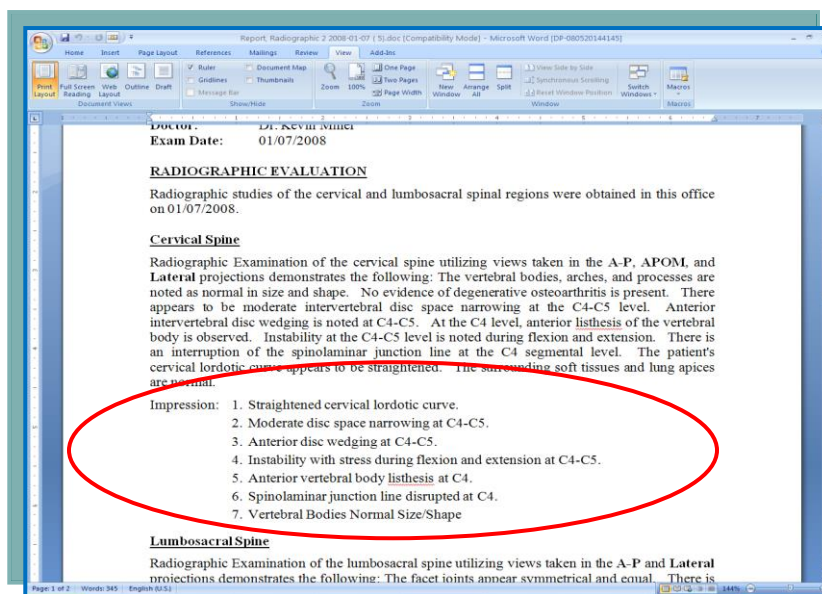
The “Active Impressions, Set Order and Modify Impressions” screen will appear. (Shown in Figure 5 below)

Figure 5 – “Active Impressions, Set Order and Modify Impressions” screen



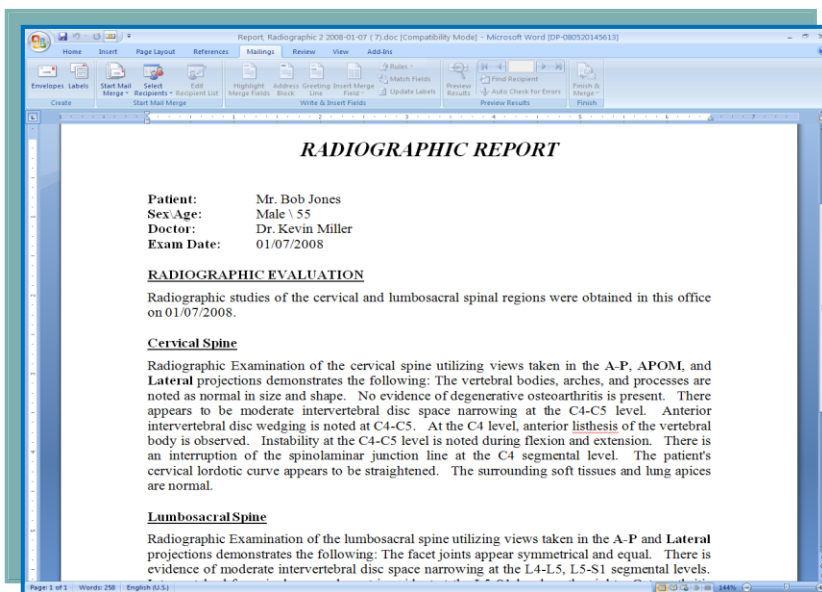
NOTE: You can select an order for your impressions in the above screen by using the up/down arrows to select the impression then clicking on “Add”. The report will appear similar to the one in Figure 6, Pg. 122.

Figure 6 – “Report, Radiographic 2” – Impressions, Ordered



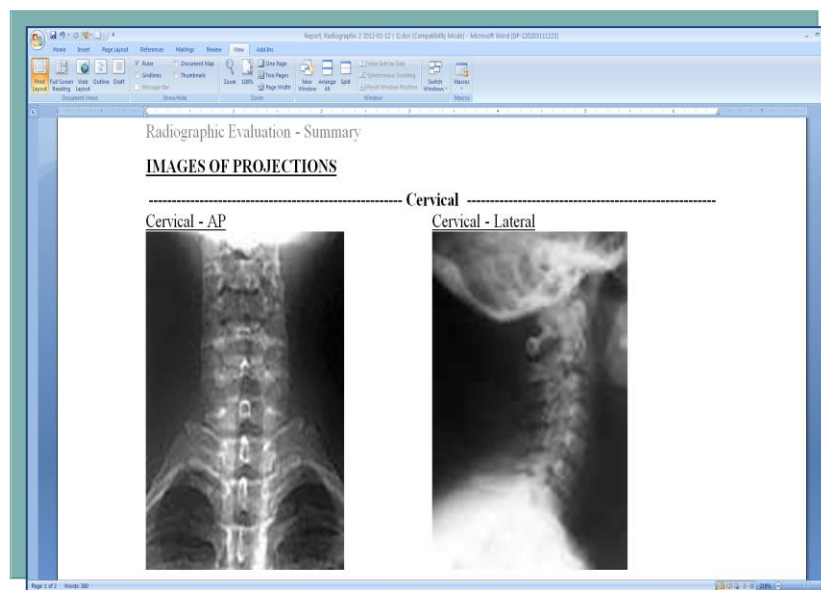
NOTE: If you do not choose to select an order, the report will appear similar to the one in Figure 7 below.

Figure 7 – “Report, Radiographic 2” – Impressions, Not ordered



Images will appear in your reports as shown in Figure 8, Pg. 123.

Figure 8 – “Report, Radiographic 2” – Images



APPENDIX I – Word Processing

Microsoft Word

1. From the Main Menu click **“Generate Documents”**.
2. Select patient **“Bob Jones”**.
3. Once in the **“Generate Documents”** screen for Bob Jones, click to check the box next to **“Initial Patient History”**.
4. Click **“Generate”**.
5. Once the **“Initial Patient History”** is generated and appears as a Microsoft Word document, **maximize** the active window by double clicking on the title bar.
6. Print the document using the printer icon on the toolbar or click **“File”** then **“Print”**.
7. Click **“Ok”** to print one copy.

NOTE: If you have a color printer you will want to click **“blacktext”** on the toolbar BEFORE you print. This will change the color of all text in the current document to black.

8. Repeat steps 3-7 for any other documents you would like to generate and print.
9. Once you have reviewed your documents, close using the DocumentPlus icon (looks like a hand holding a pencil, located under **“File”**) or close Microsoft Word.
10. Click Main Menu in the **“Generate Documents”** screen to return to the Main Menu.

Word Documents – As Listed in Document Plus

Word Name	Word Name
Summary, Patient History	Insurance, Final
Summary, Clinical Evaluation	Referring, Initial
Summary, Re-evaluation	Referring, Interim
Summary, Radiographic	Referring, Final
Summary, Accident/Injury	Refer To, Initial
Summary, Automobile Accident	Refer To, Interim
Summary, Health Status RPF	Refer To, Final
Summary, Health Status	Personal Phys, Initial
Summary, Neck Pain Disability	Personal Phys, Interim
Summary, RM Acute Low Back	Personal Phys, Final
Summary, Revised Oswestry	Patient Welcome
DN (Daily Note)	Summary Abbreviated RPT
Attorney Note, Initial	HMO Exam Author Form
Attorney Note, Interim	HMO Interim Author Form
Attorney Note, Final	Patient ROF
Insurance, Initial	DN (Daily Note)
Insurance, Interim	

Microsoft Word – Saving Reports

Original reports are automatically saved. Any changes made to the document after it has been generated in word will need to be saved. Follow the instructions below to save your reports for future editing and printing.

1. While the word document is up on the screen, select **“File”**, then **“Save”** or click the disk icon on the toolbar.
2. Patient folders have been created to separate patient reports. The reports are stored in folders according to the first letter of the patient's last name. Each patient has a personal folder within the letter folder.
3. When you need to retrieve a specific document, it can be accessed in Microsoft Word by clicking **“File”**, **“Open”**. Microsoft Word can be accessed from the Main Menu of DocumentPlus by clicking on the MS Word button on the lower left hand corner of your screen.

It is highly recommended that you always make changes to documents in the query screens in Document Plus and NOT by editing directly in Microsoft Word.

Once the document is generated, if you need to make changes to the blue text you should always return to the **“Generate Documents”** screen, click to select the **“Query Edit”** box on the right and **“Generate”** the document again. All query screens will re-appear. Click **“OK”** or **“Empty”** until the one you want to edit appears.

Microsoft Word – Find and Replace

Follow these instructions to automatically replace words or phrases in any document, with words or phrases you specify.

1. Generate or open the document that contains the words you want to replace.
2. On the menu bar, click **“Edit”** then **“Replace”**.
3. You should see a small dialog box labeled **“Find And Replace”**.
4. In the **“Replace”** dialog box **“Find what”** field, type the word or phrase you want to replace. In the **“Replace With”** field, type in the text you want to appear.
5. Click **“Replace all”** and click **“OK”** in the **“replace notification”** box that appears.
6. Click **“Close”** in the **“Replace”** dialog box.

If you need further training or technical support please call 800-642-0600 or 770-814-2442.

APPENDIX J – Abbreviations

The travel card section of the daily note contains abbreviations. Most of these are standard in the industry and easy to understand. This section outlines the syntax rules that define how the abbreviations are linked.

Travel Card Syntax Rules

1. Capital Letters- Use for the first letter of each word that is part of an abbreviation.
Deep Tendon Reflexes

Example DTR

2. Double Colon – Indicates a section of the examination
Neurological Assessment

Example Neuro::

3. Single Colon – Identifies a group of tests
Cervical – Range of Motion

Example Cerv:: ROM:

4. Equal Sign - Indicates that a test has multiple findings
Cervical – Compression Tests – Flexion

Example Cerv::Cmp:Flx=

5. Comma – Separates multiple tests of a group
Thoracic – Spinal Exam – T1 Right Spasm & T2 Right Tenderness

Example Thor:: SpnEx: T1=RtSp, T2=RtTn

6. Semicolons – Separates test groups and individual tests
Cervical- Compression Tests – Flexion is Positive with Back Pain and Extension is Positive with Bilateral Leg Pain - Range of Motion – Flexion is Moderately Restricted and Right Lateral Flexion is Severely Restricted

Example Cerv::Cmp:Flx=BkP, Ext=BiLgP; ROM: Flx=MoRs, RtLatFlx=SrRs;

7. Period - Terminates a section
Lumbosacral – Spinal Exam –l5 Bilateral Spasm- Sacriiliac Malpostiion – straight Leg Raise – On Right Back Pan at 40 egress- Kemps – To right Reveals Right Leg Pain

Example LS::SpnEx: L5=BiSp, Sac=Mp; SLR: Rt=BkP@40; Kmp:Rt=RtLgP.

8. Exclamation Point – Terminates a report
Example Neuro::DTR: Bic=Rt1\Lt), Tri=Rt3\Lt1; Plt=RtAbs\LtUpg. Cerv:: Cmp: Flx=BkP, Ext=BiLgP; ROM: Flx=MoRs, RtLatFlx=SrRs. LS:: SpnEx: L5=BiSp, Sac=Mp; SLR:Rt=BkP@40; Kmp: Rt=RtlgP!
9. Plus Sign – Combines multiple findings of a test/location
 Thoracic- Spinal Exam- T1 Right Spasm & Right Tenderness and T2 Right Tenderness & Malposition
Example Thor:: SpnEx: T1=RtSp+RtTn, T2= RtTn+Mp
10. Backslash – Separates single right and left findings
 Neurological Assessment – Plantar Response – Right Absent and Left Upgoing
Example Nur::DTR: Bic=Rt1\Lt0, Tri= Rt3\Lt1; Plt=RtAbs\LtUpg.
11. Test Name Only – Test is Positive
 Lumbosacral – Lindner is Positive – Minor's Sign is Positive
Example LS::Lnd;Mnr.
12. Right\Left\Bilateral With Preceding Name – Test can be positive on either or both sides.
 Lumbosacral – Braggard Positive on Right- Fabere Patrick Positive Bilaterally – Right Flexed Antalgic Lean
Example LS::RtBrg;BiFbP; RtFlxAnl.
13. Spinal Exam with Midline Tenderness
 Cervical – Spinal Exam – C1 Midline Tenderness – C2 Right and Midline Tenderness – C3 Left and Midline Tenderness – C4 Bilateral Tenderness
Example Cerv::SpnEx: C1= M1Tn; C2=Rt\M1Tn; C3=Lt\M1Tn, C4=BiTn;

Abbreviations

The following sections will provide you with the abbreviations used throughout the travel card sections of the daily note form. The designated abbreviations are industry average and are easily referenced to their intended meaning.

- SECTION 1:** Clinical Evaluation
- SECTION 2:** Health Questionnaire/Daily Note Complaints
- SECTION 3:** Diagnoses
- SECTION 4:** X-ray
- SECTION 5:** Therapy-Modalities

Section 1 – Clinical Evaluation

Neurological Assessment (**Nuro**)

Carotid Pulsations (**CP**)

CP=Right (**Rt**)*finding* Left (**Lt**)*finding* | Bilateral(**Bi**)*finding*
finding = 0 | 1

CP=Rt0

CP=Rt0Lt1

CP=Bi1

Bruit (**Brt**)

Brt:*present*Carotid(**Car**), *present*Subclavian(**Scl**)
present = Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)

Brt=RtCat, BiScl

Craniocervical Functional Maneuver (**CFM**)

[Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)]CFM

LtCFM

Cranial Nerves (**CN**)

CN=CN I (**I**), CN II (**II**), CN III (**III**), CN IV (**IV**), CN V (**V**), CN VI (**VI**),
CN VII (**VII**), CN VIII (**VIII**), CN IX (**IX**), CN X (**X**), CN XI (**XI**), CN XII (**XII**)

CN=II, XI

Gait (**Gt**)

Dystaxia (**Dys**) Gt

DysGt

Rapidly Alternating Movements (**RAM**)

RAM=Right (**Rt**)*finding* Left (**Lt**)*finding* | Bilateral (**Bi**)*finding*
finding = Clumsily (**Clm**) | Unable To Perform (**UTP**)

RAM=RtClmLtUTP

RAM=BiClm

Heel To Shin (**HTS**)

HTS=Right (**Rt**)*finding* Left (**Lt**)*finding* | Bilateral (**Bi**)*finding*
finding = Clumsily (**Clm**) | Unable To Perform (**UTP**)

HTS=LtClm

Deep Tendon Reflexes (**DTR**)

DTR: Biceps (**Bic**)=*finding*, Triceps (**Tri**)=*finding*, Brachioradialis (**Bra**)=*finding*,
Patellar (**Pat**)=*finding*, Achilles (**Ach**)=*finding*
finding = Right(**Rt**)[0|1|3|4] Left(**Lt**)[0|1|3|4] | Bilateral (**Bi**)[0|1|3|4]

DTR: Bic=Rt0, Tri=Lt4, Bra=Rt3Lt4, Pat=Bi1

Upper Extremity Motor Examination (**UExtMF**)

UExtMF: Shoulder Abduction (**ShrAb**)=*finding*, Wrist Extension (**WstEx**)=*finding*,

Wrist Flexion (**WstFlx**)=*finding*, Finger Extension (**FngEx**)=*finding*,
 Finger Flexion (**FngFlx**)=*finding*, Finger Abduction (**FngAb**)=*finding*,
 Finger Adduction (**FngAd**)=*finding*
finding = Right (**Rt**)[0|1|2|3|4] Left (**Lt**)[0|1|2|3|4] | Bilateral (**Bi**)[0|1|2|3|4]

UExtMF: ShrAb=Rt0, WstEx=Lt1, WstFlx=Rt3Lt4, FngEx=Bi0

Lower Extremity Motor Examination (**LExtMF**)

LExtMF: Hip Flexion (**HpFlx**)=*finding*, Leg Extension (**LgEx**)=*finding*,
 Foot Dorsi-Flexion (**FtDFlx**)=*finding*,
 Great Toe Dorsi-Flexion (**GTDFlx**)=*finding*,
 Foot Plantar-flexion (**FtPFlx**)=*finding*,
 Great Toe Plantar-flexion (**GTPFlx**)=*finding*, Foot Eversion (**FtEv**)=*finding*,
finding = Right (**Rt**)[0|1|2|3|4] Left (**Lt**)[0|1|2|3|4] | Bilateral (**Bi**)[0|1|2|3|4]

LExtMF: HpFlx=Rt0, LgEx=Lt1, FtDFlx=Rt2Lt3, GTDFlx=Rt0Lt4

Heel Walk (**HW**)

[Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)]HW

RtHW

Toe Walk (**TW**)

[Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)]TW

BiTW

Sensory Deficit (**SenDef**)

SenDef: C1=*finding*, ... T1=*finding*, ... L1=*finding*, ... S5=*finding*
finding = Right (**Rt**)[Hypo (**Hyo**) | Hyper (**Hyp**)]
 Left (**Lt**)[Hypo(**Hyo**) | Hyper(**Hyp**)]

SenDef: C3=RtHyo, T8=LtHyp, L3=RtHypLtHyo

Plantar Response (**Plt**)

Plt=Right (**Rt**)*finding* Left (**Lt**)*finding* | Bilateral(**Bi**)*finding*
finding = Absent (**Abs**) | Upgoing (**Upg**)

Plt=RtAbsLtUpg

Plt=BiUpg

Cervical Region Orthopedic and Spinal Examination (**Cerv**)

Spinal Examination (**SpnEx**)

SpnEx: Occ=*finding*, ... C7=*finding*
finding = [Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)] Spasm (**Sp**) +
 [[Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)] Midline (**Ml**)] Tenderness (**Tn**) +
 Articular Fixation (**AF**) + Malposition (**Mp**)

SpnEx: C1=BiSp, C2=RtSp+BiMlTn, C3=RtSp+AF+Mp, C4=RtMlTn

Compression Test (**Cmp**)

Cmp: Neutral (**Nt**)=*finding*, Flexion (**Flx**)=*finding*, Extension (**Ext**)=*finding*,
 Right Lateral Flexion(**RtLatFlx**)=*finding*, Left Lateral Flexion(**LtLatFlx**)=*finding*
finding = + |
 [Neck Pain (**NkP**) +

[Right Upper Extremity Pain (**RtUEP**) |
 Left Upper Extremity Pain (**LtUEP**) |
 Bilateral Upper Extremity Pain (**BiUEP**)]]

Cmp: Nt=+, Flx=NkP, Ext=RtUEP, RtLatFlx=NkP+BiUEP

Valsalva (**Val**)

Val

Distraction (**Dst**)

Dst

Range Of Motion (**ROM**)

ROM: Flexion (**Flx**)=*finding*, Extension (**Ext**)=*finding*,

Right Lateral Flexion(**RtLatFlx**)=*finding*, Left Lateral Flexion(**LtLatFlx**)=*finding*,

Right Rotation(**RtRot**)=*finding*, Left Rotation(**LtRot**)=*finding*

finding = [Mildly Restricted (**MiRs**) | Moderately Restricted (**MoRs**) |
 Severly Restricted (**SrRs**)] + Pain (**P**)

ROM: Flx=MoRs, Ext=SrRs+P, RtLatFlx=P

Thoracic Region Spinal Examination (**Thor**)

Spinal Examination (**SpnEx**)

SpnEx: T1=*finding*, ... T12=*finding*

finding = [Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)] Spasm (**Sp**) +
 [[Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)] Midline (**MI**)] Tenderness (**Tn**) +
 Articular Fixation (**AF**) + Malposition (**Mp**)

SpnEx: T1=BiSp, T2=RtSp+BiMI Tn, T3=RtSp+AF+Mp, T4=RtMI Tn

Lumbosacral Region Orthopedic and Spinal Examination (**LS**)

Spinal Examination (**SpnEx**)

SpnEx: L1=L-*finding*,...L5=L-*finding*,...Sac=L-*finding*1, SI=SI-*Finding*2, Coc=Coc-*Finding*3

L-finding = [Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)] Spasm (**Sp**) +
 [[Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)] Midline (**MI**)] Tenderness (**Tn**) +
 Articular Fixation (**AF**) + Malposition (**Mp**)

SI-finding =[Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)] Spasm (**Sp**) +
 [Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)] Tenderness (**Tn**) +
 [Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)] Articular Fixation (**AF**) +
 [Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)] Malposition (**Mp**)

Coc-finding =Tenderness (**Tn**) + Articular Fixation (**AF**) + Malposition (**Mp**)

SpnEx: L1=BiSp, L2=RtSp+Bi\MI Tn+AF+Mp, Sac=RtMI Tn, SI=BiSp+Bi Tn, Coc=Tn+Mp

Straight Leg Raise (**SLR**)

SLR: Right (**Rt**)=*finding*, Left (**Lt**)=*finding*

finding = Back Pain (**BkP**) + Leg Pain (**LgP**) @ 30 | 45 | 60 | 90

SLR: Rt=BkP

SLR: Rt=LgP@45, Lt=BkP+LgP@60

Braggard's (**Brg**)

[Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)]Brg

RtBrg

Well Leg Raise (**WLR**)
[Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)]WLR

LtWLR
Lindner (**Lnd**)
Lnd
Valsalva (**Val**)
Val

Kemp's (**Kmp**)
Kmp: Right (**Rt**)=*finding*, Left (**Lt**)=*finding*,
finding = Back Pain (**BkP**) + [Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)] Leg Pain (**LgP**)

Kmp: Rt=BkP+BiLgP, Lt=RtLgP.
Fabere Patrick (**FbP**)
[Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)]FbP

LtFbP
Minor's (**Mnr**)
Mnr
Adam's (**Adm**)
Adm

Antaigia (**AnL**)
[[Right (**Rt**) | Left (**Lt**)] Flexion(**Flx**)]AnL

RtAnL
LtFlxAnL
Range Of Motion (**ROM**)
ROM: Flexion (**Flx**)=*finding*, Extension (**Ext**)=*finding*,
Right Lateral Flexion(**RtLatFlx**)=*finding*, Left Lateral Flexion(**LtLatFlx**)=*finding*,
Right Rotation(**RtRot**)=*finding*, Left Rotation(**LtRot**)=*finding*
finding = [Mildly Restricted (**MiRs**) | Moderately Restricted (**MoRs**) |
Severly Restricted (**SrRs**)] + Pain (**P**)

ROM: Flx=MoRs, Ext=SrRs+P, RtLatFlx=P

Examples

1.) Version from the Travel Card:

Nuro:: CP=Rt0\Lt1; Brt=RtCar, BiScl; RtCFM; CN=II, III; RAM=RtClm\LtUTP; HTS=BiClm; DTR:
Bic=Rt1, Tri=Bi1; UExtMF: FngAb=Rt3, FngAd=Bi4; LExtMF: GTDFlx=Rt4; RtHW; BiTW;
SenDef: C1=RtHyo, C2=RtHyp\LtHyo; Plt=RtAbs\LtUp. Cerv:: SpnEx: C4=RtSp+RtTn+Mp,
C5=RtSp+RtTn+Mp, C6=RtSp+RtTn+Mp, C7=RtSp+RtTn+Mp; Cmp: Flx=NkP, Ext=BiUEP,
RtLatFlx=NkP+LtUEP, LtLatFlx=NkP+BiUEP; Val; Dst; ROM: Flx=MoRs, Ext=SrRs+P. Thor::
SpnEx: T1=BiSp+Bi\MlTn+AF+Mp, T2=BiSp+Bi\MlTn+AF+Mp, T3=BiSp+Bi\MlTn+AF+Mp. LS:: SpnEx:
L5=RtSp+Rt\MlTn+Mp, Sac=RtSp+Rt\MlTn+Mp, SI=RtSp+RtTn+RtMp;

SLR=RtBkP@40\LtBkP+LgP@60; RtBrg; BiWLR; Lnd; Val; Kmp: Rt=BkP+LtLgP, Lt=BkP+BiLgP; BiFbP; Mnr; Adm; RtFlxAnL; ROM: Flx=MoRs, Ext=SrRs+P, RtLatFlx=P.

2.) Version from the Abbreviated Report

Clinical Evaluation 09/03/97

Nuro CP=Rt0\Lt1; Brt=RtCar, BiScL; RtCFM; CN=II, III; RAM=RtCIm\LtUTP; HTS=BiCIm; DTR: Bic=Rt1, Tri=Bi1; UExtMF: FngAb=Rt3, FngAd=Bi4; LExtMF: GTDFlx=Rt4; RtHW; BiTW; SenDef: C1=RtHyo, C2=RtHyp\LtHyo; Plt=RtAbs\LtUpg.

Cerv SpnEx: C4=RtSp+RtTn+Mp, C5=RtSp+RtTn+Mp, C6=RtSp+RtTn+Mp, C7=RtSp+RtTn+Mp; Cmp: Flx=NkP, Ext=BiUEP, RtLatFlx=NkP+LtUEP, LtLatFlx=NkP+BiUEP; Val; Dst; ROM: Flx=MoRs, Ext=SrRs+P.

Thor SpnEx: T1=BiSp+Bi\MItn+AF+Mp, T2=BiSp+Bi\MItn+AF+Mp, T3=BiSp+Bi\MItn+AF+Mp.

LS SpnEx: L5=RtSp+Rt\MItn+Mp, Sac=RtSp+Rt\MItn+Mp, SI=RtSp+RtTn+RtMp; SLR: Rt=BkP@40, Lt=BkP+LgP@60; RtBrg; BiWLR; Lnd; Val; Kmp: Rt=BkP+LtLgP, Lt=BkP+BiLgP; BiFbP; Mnr; Adm; RtFlxAnL; ROM: Flx=MoRs, Ext=SrRs+P, RtLatFlx=P.

Section 2 – Health Questionnaire/Daily Note Complaints

Complaints (Cmplts)

Cmplts: Location-1=complaints, Location-2=complaints .. , Location-n=complaints

Note: HQ-0 no right/left for Head, Neck, Upper Back, Mid Back, and Low Back

Locations = [Right | Left | Bilateral |] Head ([Rt | Lt | Bi |]Hd) |
 [Right | Left | Bilateral |] Neck ([Rt | Lt | Bi |]Nk) |
 [Right | Left | Bilateral |] Upper Back ([Rt | Lt | Bi |]UBk) |
 [Right | Left | Bilateral |] Mid Back ([Rt | Lt | Bi |]MBk) |
 [Right | Left | Bilateral |] Low Back ([Rt | Lt | Bi |]LBk) |
 [Right | Left] Shoulder ([Rt | Lt]Shdr) |
 [Right | Left] Arm ([Rt | Lt]Arm) |
 [Right | Left] Elbow ([Rt | Lt]Elb) |
 [Right | Left] Fore Arm ([Rt | Lt]FArm) |
 [Right | Left] Wrist ([Rt | Lt]Wrt) |
 [Right | Left] Hand ([Rt | Lt]Hnd) |
 [Right | Left] Rib ([Rt | Lt]Rib) |
 [Right | Left] Buttock ([Rt | Lt]But) |
 [Right | Left] Hip ([Rt | Lt]Hip) |
 [Right | Left] Thigh ([Rt | Lt]Thg) |
 [Right | Left] Leg ([Rt | Lt]Leg) |
 [Right | Left] Knee ([Rt | Lt]Kne) |
 [Right | Left] Ankle ([Rt | Lt]Ank) |
 [Right | Left] Foot ([Rt | Lt]Ft)

complaints = Symptoms) c>characteristics) i>intensity) f>frequency) s>Status

symptoms = Pain (**P**) "+" Numbness (**Nmb**) "+" Tingling (**Tng**) "+"
 Stiffness (**Stf**) "+" Soreness (**Sor**) "+" Weakness (**Wek**) "+"
 Swelling (**Swl**)
characteristics = Burning (**Brn**) "+" Dull (**Dll**) "+" Sharp (**Shp**) "+"
 Shooting (**Sht**) "+" Stinging (**Stg**) "+" Throbbing (**Thb**)
intensity = Mild (**Mi**) | Moderate (**Mo**) | Severe (**Sr**)
frequency = Occasional (**Oc**) | Intermittent (**In**) | Frequent (**Fr**) | Constant (**Cn**)
Status = Improving (**Im**) | Worsening (**Wo**) | Unchanged (**Un**) | Resolved (**Rs**)

From HQ (initial)

cmplts: BiNk=P, RtUBk=P+Sor, RtShdr=P+Nmb+Tng+Stf

From DN (current)

cmplts: BiNk=P) i>Sr) f>Cn) s>Wo, RtUBk=P+Sor) c>Brn) i>Mo) f>Fr) >Uc,
 RtShdr=P+Nmb+Tng+Stf) c>Shp+Sht+Stg) i>Mi) f>Oc) s>Im

Section 3 – Diagnoses

Code	Abbreviation	Description
353.0	Thor Outlet Syn	Thoracic Outlet Syndrome
524.6	TMJ Syn	Temporomandibular Joint Syndrome
721.0	Cerv Spondylosis	Cervical Spondylosis
722.0	Cerv Disc Disp/Hern	Cervical Disc Displacement/Herniation
722.4	Cerv Disc Degen	Cervical Disc Degeneration
723.1	Cerv Spine Pain	Cervical Spine Pain
723.2	Cerv-cranial Syn	Cervicocranial Syndrome
723.3	Cervi-brachial Syn	Cervicobrachial Syndrome
723.4	Cerv Radi Root Comp	Cervical Radiculitis Root Compression
729.1	Cerv Myofascitis	Cervical Myofascitis
739.1	Cerv Seg Dysf/Sublux	Cervical Segmental Dysfunction/Subluxation
756.10	Cerv Congenital Anom	Cervical Congenital Anomaly
847.0	Cerv Sprain/Strain	Cervical Sprain/Strain
353.8	Thor Intrcost Neuritis	Thoracic Intercostal Neuritis
354.8	Thor Scapcost Syn	Thoracic Scapulocostal Syndrome
721.2	Thor Spondylosis	Thoracic Spondylosis
722.11	Thor Disc Disp/Hern	Thoracic Disc Displacement/Herniation
722.51	Thor Disc Degen	Thoracic Disc Degeneration
724.10	Thor Spine Pain	Thoracic Spine Pain
724.4	Thor Radi/Root Comp	Thoracic Radiculitis/Root Compression
729.1	Thor Myofascitis	Thoracic Myofascitis
739.2	Thor Seg Dysf/Sublux	Thoracic Segmental Dysfunction/Subluxation
737.10	Thor Kyphosis	Thoracic Kyphosis
737.30	Thor Scoliosis	Thoracic Scoliosis
756.10	Thor Congenital Anom	Thoracic Congenital Anomaly
847.1	Thor Sprain/Strain	Thoracic Sprain/Strain
848.3	Thor Rib/Intrcost Strn	Thoracic Rib/Intercostal Strain

721.3	LS Spondylosis	Lumbar Spondylosis
722.10	LS Disc Disp/Hern	Lumbar Disc Displacement/Herniation
722.52	LS Disc Degen	Lumbar Disc Degeneration
724.02	LS Stenosis	Lumbar Stenosis
724.2	LS Pain	Lumbar Pain
724.3	LS Sciatica	Lumbar Sciatica
724.4	LS Root Comp	Lumbar Root Compression
724.8	LS Facet Syn	Lumbar Facet Syndrome
729.1	LS Myofascitis	Lumbar Myofascitis
739.3	LS Seg Dysf/Sublux	Lumbar Segmental Dysfunction/Subluxation
756.10	LS Congenital Anom	Lumbar Congenital Anomaly
756.10	LS Asymmet Facets	Lumbar Asymmetrical Facets
847.2	LS Sprain/Strain	Lumbar Sprain/Strain
715.15	Hip Osteoarthritis	Pelvic Osteoarthritis Of Hip
724.6	Sacroiliac Syn	Pelvic Sacroiliac Syndrome
736.81	Limb Shrtnng (Acq)	Pelvic Limb Shortening (Acquired)
738.4	Pel Spndlsths (Acq)	Pelvic Spondylolisthesis (Acquired)
755.30	Limb Shrtnng (Cong)	Pelvic Limb Shortening (Congenital)
781.9	Pel Abnorm Posture	Pelvic Abnormal Posture
846.1	Sacroiliac Sprain	Pelvic Sacroiliac Sprain
726.1	Rotator Cuf/Shld Syn	Peripheral Joints Rotator Cuff/Shoulder Syndrome
726.31	Med Epicon Elbow	Peripheral Joints Medial Epicondylitis Elbow
726.32	Lat Epicon Elbow	Peripheral Joints Lateral Epicondylitis Elbow
840.0	Shld Sprain/Strain	Peripheral Joints Shoulder Sprain/Strain
841.0	Elbow Sprain/Strain	Peripheral Joints Elbow Sprain/Strain
844.0	Knee Sprain/Strain	Peripheral Joints Knee Sprain/Strain
845.0	Ankle Sprain/Strain	Peripheral Joints Ankle Sprain/Strain
	Patellofemoral Dysf Syn Syndrome	Peripheral Joints Patellofemoral Dysfunction
0.0	Cerv Other 1	Cervical Other 1
0.0	Cerv Other 2	Cervical Other 2
0.0	Thor Other 1	Thoracic Other 1
0.0	Thor Other 2	Thoracic Other 2
0.0	LS Other 1	Lumbosacral Other 1
0.0	LS Other 2	Lumbosacral Other 2
0.0	Pel Other	Pelvic Other
0.0	Perp Jnts Other 1	Perippheral Joints Other 1
0.0	Perp Jnts Other 2	Perippheral Joints Other 2

Section 4 – X-Ray

Cervical Spine Evaluation (**Cerv**)

Generalized Osteoporosis (**GOp**)

Mild (**Mi**) | Moderate (**Mo**) | Severe (**Sr**) GOp

MiGOp

Lytic/Blastic Changes (**L/B**)

L/B

Degenerative Changes

Narrowed Dis Spacing (**NDS**)

NDS=C1/C2, ... C6/C7

NDS=C1/C2, C2/C3, C3/C4

Posterior Spurring (**PsSp**)

PsSp=Occ/C1, ... C6/C7

PsSp=C2/C3, C3/C4, C4/C5

Anterior Spurring (**AnSp**)

AnSp=Occ/C1, ... C6/C7

AnSp=C4/C5

Right Foraminal Encroachment (**RtFoEn**)

RtFoEn=Occ/C1, ... C6/C7

RtFoEn=C2/C3, C3/C4, C4/C5

Left Foraminal Encroachment (**LtFoEn**)

LtFoEn=Occ/C1, ... C6/C7

LtFoEn=C2/C3, C3/C4, C4/C5

Scoliosis (**Scs**)

Scs= [Right (**Rt**) | Left (**Lt**)] [Mild (**Mi**) | Moderate (**Mo**) | Severe (**Sr**)]
@ [C2 | C2/C3 ... C6/C7 | C7]

Scs=RtSr@C6/C7

Scs=Rt

Antalgic Lean (**AnL**)

[Right (**Rt**) | Left (**Lt**)] Flexion (**Flx**) AnL

RtFlxAnL

Normal Curve To The Anterior (**NCA_n**)

Well Maintained (**WM**) | Straightened (**St**) | Reduced (**Rd**) | Reversed (**Rv**) NCA_n

WMNCA_n

Thoracic Spine Evaluation (**Thor**)

Generalized Osteoporosis (**GOp**)

Mild (**Mi**) | Moderate (**Mo**) | Severe (**Sr**) GOp

MoGOp

Lytic/Blastic Changes (**L/B**)

L/B

Degenerative Changes

Narrowed Dis Spacing (**NDS**)

NDS=C7/T1, ... T11/T12

NDS=T1/T2, T2/T3, T3/T4

Posterior Spurring (**PsSp**)

PsSp=C7/T1, ... T11/T12

PsSp=T2/T3, T3/T4, T4/T5

Anterior Spurring (**AnSp**)

AnSp=C7/T1, ... T11/T12

AnSp=T4/T5

Right Foraminal Encroachment (**RtFoEn**)

RtFoEn=C7/T1, ... T11/T12

RtFoEn=T2/T3, T3/T4, T4/T5

Left Foraminal Encroachment (**LtFoEn**)

LtFoEn=C7/T1, ... T11/T12

LtFoEn=T2/T3, T3/T4, T4/T5

Scoliosis (**Scs**)

Scs= [Right (**Rt**) | Left (**Lt**)] [Mild (**Mi**) | Moderate (**Mo**) | Severe (**Sr**)]
@ [T1 | T1/T2 ... T11/T12 | T12]

Scs=RtMo@T6/T7

Scs=LtMi

Lumbosacral Spine Evaluation (**LS**)

Generalized Osteoporosis (**GOp**)

Mild (**Mi**) | Moderate (**Mo**) | Severe (**Sr**) GOp

SrGOp

Lytic/Blastic Changes (**L/B**)

L/B

Degenerative Changes

Narrowed Dis Spacing (**NDS**)

NDS=T12/L1, ... L5/S1

NDS=T12/L1, L1/L2, L2/L3

Posterior Spurring (**PsSp**)

PsSp=T12/L1, ... L5/S1

PsSp=L2/L3, L3/L4, L4/L5

Anterior Spurring (**AnSp**)

AnSp=T12/L1, ... L5/S1

AnSp=L5/S1

Right Foraminal Encroachment (**RtFoEn**)

RtFoEn=T12/L1, ... L5/S1

RtFoEn=L2/L3, L3/L4, L4/L5

Left Foraminal Encroachment (**LtFoEn**)

LtFoEn=T12/L1, ... L5/S1

LtFoEn=L2/L3, L3/L4, L4/L5

Scoliosis (**Scs**)

Scs= [Right (**Rt**) | Left (**Lt**)] [Mild (**Mi**) | Moderate (**Mo**) | Severe (**Sr**)]

@ [L1 | L1/L2 ... L5/S1 | S1]

Scs=LtMi@L1/L2

Scs=Rt@L2

Antalgic Lean (**AnL**)

[Right (**Rt**) | Left (**Lt**)] Flexion (**Flx**) AnL

RtFlxAnL

Spondylolisthesis (**Spls**)

Spls: [L5 | Other]= Spondylitic (**Spc**)*grade*, Degenerative (**Dg**)*grade*
grade = 1 | 2 | 3 | 4 | 5

Spls: L5=Spc2

Spls: L5=Spc2, S1=Dg5

Facet Imbrication (**FcI**)

FcI=L4/L5, L5/S1, Other

FcI=L4/L5, L5/S1

Disruption Of George's Line (**DsGL**)

DsGL=L4/L5, L5/S1, Other

DsGL=L4/L5, L5/S1

Facet Asymmetry (**FcA**)

FcA: L4/L5=*finding*, L5/S1=*finding*, Other=*finding*

finding = [Right (**Rt**) | Left (**Lt**)]sagittal (**Sag**) + [Right (**Rt**) | Left (**Lt**)]coronal (**Cor**)

FcA: L4/L5=RtSag+LtCor, L5/S1=LtSag+RtCor

Sagittal Diameter Of Spinal Canal (**SDSc**)

SDSc: L4=*dia*, L5=*dia*, Other=*dia*

SDSc: L4=.04, L5=.03

Anomalous Transitional Lumbosacral Segment

Sactalization Of L5 (**SacL5**); Lumbarization Of S1 (**LumS1**);

[Right (**Rt**) | Left (**Lt**) | Bilateral (**Bi**)] Nearthroses (**Nar**)

SacL5; LumS1; BiNar

Section 5 – Therapy - Modalities

Ice (**Ice**)

Diathermy (**Diath**)

Hydro Therapy (**HyTh**)

Moist Heat (**MHt**)

Interseg Traction (**IT**)

Mech. Traction (**MT**)

Massage (**Mss**)

Ultrasound (**Us**)

Ischemic Comp. (**IC**)

LV Galvanic (**LV**)

HV Galvanic (**HV**)

Interferential (**If**)

Russian Stim (**RS**)

Myo/Rel (**Myo/Re**)

joint mobilization (**Jt/Mob**)

Locations

Head Hd

UML-Cerv

UML-Tho

UML-LS

Rt-SI

Lt-SI

RtU-Extr

LtU-Extr

RtL-Extr

LtL-Extr